Critical Strategies of Narrating Mental Illness in Contemporary Life Writing

Katrina Anne Longhurst

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Abstract

In this thesis I examine contemporary life writing about mental illness published in the UK and USA. I focus on memoirs that exceed and disrupt conventional narrative typologies of overcoming, triumph, and quest, which dominate in contemporary culture and critical thought. I analyse prose and graphic texts that self-consciously experiment with methods of narrating experiences of mental illness and, subsequently, complicate how such stories are read. To achieve this I develop a feminist methodology that brings together theory and approaches from the critical medical humanities, critical disability studies, critical trauma studies, autobiography studies, and, in the final chapter, comics studies. This commitment to interdisciplinarity allows me to negotiate the complex entanglements of mental illness, madness, psychiatric disability, trauma, and distress.

As such, my thesis responds to and extends calls within the critical medical humanities to adopt interdisciplinary methodologies; to attend to complicated acts of narrative; to interrogate practices of reading illness narratives; and to analyse the polyvalent work they perform. My readings explore writers' critiques of their diagnosis, the intersections of mental illness and histories of sexual violence, relationality and interdependence, and the embodied nature of mental illness. Through these textual analyses I identify a set of critical strategies – including ambiguity, entanglement, polyvocality, and hybridity – through which my selection of writers convey their lived experiences of mental illness. My sustained emphasis on process and form is not merely driven by aesthetic interest, but by a recognition that these kinds of transgressive narratives, precisely because of their difficulty, have much to say about the ongoing complexities and messiness of living with mental illness. I argue that these writers use such critical strategies not only to destabilise assumptions about living with mental illness, but also to disrupt attempts to contain, control, and categorise how such experiences are told in narrative.

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Introduction: life writing, mental illness, and the critical medical humanities

Speaking about her graphic memoir, *Lighter than my Shadow* (2013), a story about anorexia and abuse, Katie Green remembers how, when discussing the book with her editor at Jonathan Cape, he pointed out that 'although all of this stuff was really shit it's actually quite a nice shape for a story, it kind of flows quite nicely'.[1] In another encounter with her editor, Green recounts, laughing, he stated: 'I think you've got too many suicidal moments, you're losing the dramatic emphasis, could you choose your favourite?' *Lighter than my Shadow* depicts Green's experiences of anorexia as a teenager, her tentative initial recovery, and her relapse into disordered eating after being raped by her therapist. Green had originally wanted her memoir to be a story focused on recovery, but found that, to do so, she needed to write about her illness first.[2] When the memoir was released in the USA in 2017, Green wrote a letter to her readership on the website that advertised the book, in which she stated: 'I wished for an instruction manual, and that's what I hoped to provide. But as my own recovery unfolded and took turns I could never have anticipated I learned why such a book could not exist'.[3] Green realised that her entwined experiences of anorexia and assault meant that her memoir could not follow the linear recovery trajectory that she had originally intended. These anecdotes, from while Green was still working on the memoir and years after its initial publication, all speak to the pressures on an individual to tell a story of mental illness in a certain way. They emphasise the perceived importance of shape, flow, drama, and plot trajectory, all of which

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[1] A recording of Green speaking about the making of her memoir is available on the Graphic Medicine website. Unfortunately the website does not provide the title, location, or date of the event, so I will simply reference where to find the recording: 'Katie Green, Lighter than my Shadow' 31 December 2011 *Graphic Medicine* < https://www.graphicmedicine.org/katie-green-lighter-than-my-shadow/> [accessed 28 June 2019].

[2] Ibid.

[3] Katie Green, 'Dear Reader', *Lighter than my Shadow*, May 2017, <https://lighterthanmyshadow.com/dear-reader/ > [accessed 25 October 2018].

impact upon how a memoirist structures their expression of mental illness and distress. In doing so, they call attention to both contemporary neoliberal expectations that an individual's experiences of illness, distress, and trauma adhere to certain templates and timeframes, and to the crafted, literary nature of illness narratives.

Analysing the form of illness narratives, this thesis explores life writing about mental illness that exceeds and disrupts the narratives of overcoming and triumph that dominate in contemporary culture. It does so by analysing memoirs and auto/biographies that self-consciously experiment with their modes of articulating and narrating histories of mental illness and sexual trauma and, consequently, complicate how such stories are read. I bring together theory and approaches from the critical medical humanities, critical disability studies, critical trauma studies, and autobiography studies in order to create a framework within which I perform literary analyses of my chosen texts. This selection includes: Susanna Kaysen's *Girl, Interrupted* (1993); Lauren Slater's *Welcome to my Country* (1996) and *Lying: A Metaphorical Memoir* (2000); Alexander Masters' *Stuart: A Life Backwards* (2005); Carolyn Spiro and Pamela Spiro Wagner's *Divided Minds: Twin Sisters and Their Journey Through Schizophrenia* (2005); Patrick and Henry Cockburn's *Henry's Demons: Living With Schizophrenia, A Father and Son's Story* (2011); Ellen Forney's *Marbles: Mania, Depression, Michelangelo and Me* (2012); Katie Green's *Lighter than my Shadow* (2013); Elissa Washuta's *My Body is a Book of Rules* (2014); and Una's *On Sanity: One Day in Two Lives* (2016). Each of these texts reflects on what it means to tell, and how best to tell, stories of mental illness, madness, and distress, and this results in a heightened awareness of literary form, whether that be through feminist appropriation of documents, metaphor, and layouts; multiple writers negotiating the balance of their narrative voices and the ensuing power dynamics; or comics artists emphasising the tensions between the visual and textual in their graphic mode of narration.

In this thesis I will also analyse the ways in which these writers interrogate and critique their diagnoses and re-contextualise them as part of wider life narratives. Moving beyond the clinical setting, I analyse how gender, race, class, and trauma interact and shape a person's lived experiences of mental illness, madness, and distress, and how they narrate them. Attentive to the wider impact of mental illness upon others, the study foregrounds interdependency by analysing texts that have, to varying degrees, been co-produced. My focus on the impact of such intersections on lived experiences of mental distress and how they are narrated, combined with my analysis of power, authority, and relationality within and outside of the narratives, is integral to my feminist methodology. Throughout my analysis of these texts I identify a set of critical strategies at work, including excess, disruption, entanglement, polyvocality, and hybridity. I argue that these writers use such critical strategies not only to destabilise assumptions about living with mental illness, but also to disrupt attempts to contain, control, and categorise how experiences of mental illness and psychological distress are told in narrative.

Mental illness, disability, trauma: interdisciplinary entanglements

Although I did not know it at the time, *The Edinburgh Companion to Medical Humanities* was being compiled and edited while I was applying for funding to undertake the research in this thesis. Published in 2016, the companion marks a turning point in the direction and development of the medical humanities as a field and introduced a second, critical, wave of scholarship. I will not attempt to provide a definition or history of the medical humanities here when there are so many already available.[4] However, the critical turn fundamentally shapes the approach and ambitions of this thesis, and I want to situate this project as one working

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[4] To name a few: Johanna Shapiro, Jack Coulehan, Delese Wear and Martha Montello, 'Medical Humanities and Their Discontents: Definitions, Critiques, and Implications', *Academic Medicine: Journal of the Association of American Medical Colleges*, 84.2 (2009), 192-98; Howard Brody, 'Defining the Medical Humanities: Three Conceptions and Three Narratives', *Journal of Medical Humanities*, 32.1 (2011), 1-7; Brian Hurwitz; 'Medical Humanities: Lineage, Excursionary Sketch and Rationale', *Journal of Medical Ethics*, 39.11 (2013), 672-74; Victoria Bates and Sam Goodman, 'Critical Conversations: Establishing Dialogue in the Medical Humanities', in *Medicine, Health and the Arts: Approaches to the Medical Humanities*, ed. by Victoria Bates, Alan Bleakley and Sam Goodman (Abingdon: Routledge, 2014), pp. 3-13.

within the remit of the field’s second wave. *The Edinburgh Companion* sets out what kind of work it hopes the critical medical humanities might do. It starts by dislodging what it asserts as the foundational imaginary of the first wave of the medical humanities: the moment in which a practitioner diagnoses a patient with cancer. Without devaluing the importance of this ‘primal scene’, Anne Whitehead and Angela Woods call attention to the limitations of its investigations and question its disproportionate prominence in the field. Scholarship working on this scene, they argue, has had a markedly humanist emphasis on the individual protagonists; has frequently neglected the impact of gender, class, race, sexuality, and disability within the interaction and in the aftermath of the diagnosis; and, in failing to specify the scene’s cultural, historical and institution setting, assumes its location in the UK or US; alternative healthcare practices and interpretations of illness have also been omitted from the body of work produced about this foundational encounter.[5] Additionally, the emphasis on the clinical setting and diagnostic moment positions the humanities, if they are acknowledged at all, at the margins of the scene ‘looking at medicine looking at the patient,’ rather than embedded within it.[6] Moving forward, Whitehead and Woods call for work that expands its horizons beyond the clinic, has a greater emphasis on intersectionality, incorporates global healthcare practices, and acknowledges the work of the humanities as integral to the field, instead of as an optional add-on.

As such the introduction to *The Edinburgh Companion* builds on the influential article by William Viney, Felicity Callard and Woods that implored those working in the medical humanities to embrace entanglement and take risks.[7] Central to this article is a re-evaluation of the ways in which the humanities and social sciences might assert themselves within the

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[5] Anne Whitehead and Angela Woods, ‘Introduction’, in *The Edinburgh Companion to the Critical Medical Humanities*, ed. by Anne Whitehead and Angela Woods (Edinburgh: Edinburgh University Press, 2016), pp. 1-31 (p. 2).

[6] Ibid.

[7] William Viney, Felicity Callard, and Angela Woods, ‘Critical Medical Humanities: Embracing Entanglement, Taking Risks’, *Medical Humanities*, 41.1 (2015), 2-7.

ever-developing field. In the first wave of the medical humanities, they argue, the humanities and social sciences have occupied two, oppositional, roles: firstly, they have been characterised as being in service to biomedical science, a ‘supportive friend’[8] who accommodates and enriches biomedicine, and can be brought in as an extra pedagogical strategy in medical programmes; secondly, they have been typified as a ‘counterbalance’ to disrupt and expand what are commonly presented as the reductive, ‘restrictive and restricted’ views of biomedicine.[9] Instead of casting the humanities and social sciences in either of these two circumscribed roles, Viney, Callard, and Woods propose a new model in which, embracing ‘messy flexibility’, the disciplines are recognised as *entangled* with the biomedical sciences. Further developing this premise in their chapter in *The Edinburgh Companion*, Des Fitzgerald and Callard establish the critical medical humanities as an ‘explicitly *interdisciplinary* endeavour’ whose foci are inextricably entangled and embedded with the commitments of biomedicine.[10]

This thesis is an explicitly interdisciplinary endeavour. Undertaken within a literary studies department, it identifies as a critical medical humanities project, and stitches together theory and approaches from autobiography studies, critical disability studies, and critical trauma studies to explore a range of literary and graphic texts about experiences of mental illness, madness, and distress.[11] Embracing entanglement and risk is, I demonstrate throughout this thesis, particularly crucial to undertaking research on mental illness. Producing ethically

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[8] Brody, p. 2.

[9] Viney, Callard and Woods, p. 3.

[10] Des Fitzgerald and Felicity Callard, ‘Entangling the Medical Humanities’, in *The Edinburgh Companion to the Critical Medical Humanities*, ed. by Anne Whitehead and Angela Woods (Edinburgh: Edinburgh University Press, 2016), pp. 35-49 (p. 35).

[11] The fields of disability studies and trauma studies have enjoyed their own recent ‘critical’ turns: see Dan Goodley, ‘Dis/entangling Critical Disability Studies’, *Disability & Society*, 28.5 (2013), 631-44; and Monica J Casper and Eric Wertheimer eds., *Critical Trauma Studies: Understanding Violence, Conflict and Memory in Everyday Life* (London: New York University Press, 2016). As well as examining and fostering the intra-actions between disciplines within the medical humanities, another important thread of the medical humanities’ critical turn and its interdisciplinary endeavour was to engage more with the influences of critical theory – including feminist, queer, and postcolonial models – and, most significantly in the context of this thesis, disability studies.

engaged work on representations of mental health requires interdisciplinary awareness and a willingness to negotiate the multiple different, and frequently contested, approaches to mental illness, madness, and distress adopted by various disciplines and stakeholders. This difficulty is immediately obvious from the numerous terms available to describe these experiences.

Any choice of terminology when working on mental health is a contentious issue. There are numerous terms available and each entails a set of political connotations: should one, for example, use 'mental illness,' or 'madness,' or 'psychiatric disability,' or 'mental disability,' or 'distress,' or 'neuroatypicality'? Margaret Price's categorisation of terms is invaluable here.[12] As she illustrates, 'madness' has been reclaimed as a positive and person-centred label since the 1970s mad movement and the later Mad Pride movement of the 1990s.[13] Mad Pride is an international activist group that campaigns against clinician-centred psychiatric systems and institutions, resists biomedical models of distress and the concomitant pathologisation of their experiences, and advocates for peer-run support for those experiencing distress, whilst simultaneously affirming the validity and richness of states of mental difference.[14] 'Mental illness' introduces the discourse of (un)wellness, and while this can be problematic in its implication of a 'cure' which is not necessarily available, or welcomed (for example, by members of Mad Pride), the term usefully lies at the intersection of discourses of illness and disability. It has, however, been argued that a subsequent differentiation needs to be made between the 'healthy disabled' and the chronically ill / 'unhealthy disabled'.[15] Additionally, 'mental illness' brings with it the contested issue of the

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[12] Margaret Price, 'Defining Mental Disability', in *The Disability Studies Reader,* 4th edn, ed. by Lennard J Davis (Oxon: Routledge, 2013), pp. 298-307 (p. 298).

[13] T. Curtis, R. Dellar, E. Leslie, B. Watson (eds), *Mad Pride: A Celebration of Mad Culture* (London: Spare Change Books, 2000).

[14] Bradley Lewis, 'A Mad Fight: Psychiatry and Disability Activism', in *The Disability Studies Reader,* 4th edn, pp. 115-31.

[15] Susan Wendell, 'Unhealthy Disabled: Treating Chronic Illnesses as Disabilities', *Hypatia,* 16 (2001), 17-33.

medicalisation of ‘distress’, a term which is preferred by some service-users, but is frequently too broad to account for the diversity (and potential severity) of experiences of people with long-term mental health difficulties; added to which, not everyone who has mental illness experiences it as distressing.[16]

A ‘mental illness’ can be classified as a ‘psychiatric disability’ when it persists over an elongated time period, is not caused by a singular specific event and interferes with a person’s daily functioning. For example, Susan Gabel does not view her experience of what she terms ‘doubled depression’ as a ‘mental illness’, because her whole body feels her depression, and whilst she is not always in an episode of depression, she nevertheless carries the diagnosis of it.[17] Instead of labelling her experiences in terms of illness, Gabel argues that her depression ‘creates one way of experiencing the world and myself within the world to which I assign another term. This term represents my interpretation of my experiences in the world. I am disabled.’[18] For Gabel, this is a statement of both material and ontological weight that reflects her daily existence as well as political identity.

However, Gabel’s definition of disabled here should not be conflated with the more widely used idea of cognitive disability to indicate mental difference. Cynthia Lewiecki-Wilson has problematically linked cognitive disabilities and mental illnesses under the umbrella of ‘mental disability’ due to the fact that both someone with schizophrenia and someone with autism can experience difficulties in communicating which result in a lack of rhetorical agency.[19] Whilst the joining of mental illness and cognitive disability may work in Lewiecki-Wilson’s specific example of examining rhetorical agency, it is inadvisable because of the

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[16] H. Spandler, J. Anderson, & B. Sapey, *Madness, Distress, and the Politics of Disablement* (Bristol: Policy Press, 2015), p. 6.

[17] Susan Gabel, ‘Depressed and Disabled: Some Discursive Problems with Mental Illness’, in *Disability Discourse*, ed. by Mairian Corker and Sally French (Buckingham: Open University Press, 1999), pp. 38-46.

[18] Ibid., p. 40.

[19] Lewiecki-Wilson then continues to argue for the need to expand current understanding of rhetoricity to include collaborative and mediated rhetoric. Cynthia Lewiecki-Wilson, ‘Rethinking Rhetoric through Mental Disabilities’, *Rhetoric Review*, 22.2 (2003), 156-67.

battles that have been fought to distance cognitive disabilities from the need for cures. In this thesis I will use ‘mental illness’ and ‘psychiatric disability’ interchangeably, unless the author does not recognise their experiences within a biomedical model, in which case I will use the vocabulary employed by the particular author, or ‘distress’. None of the authors in this thesis identify as ‘mad’ so I resist imposing this term on their experiences; when I do refer to madness I do so more generally as a framework that locates distress outside of a biomedical model.

There is then the further terminological question as to whether those who experience the above be referred to as ‘clients’, or ‘patients’, or ‘service users’, or ‘service receivers’, or ‘survivors’, or ‘consumers /survivor / ex-patient’ (c/s/x). Again, each term entails a political choice.[20] ‘Client’ implies that the subject has power to choose their treatment, which is not necessarily the case with mental health services where treatments can be administered involuntarily. At the other end of the spectrum, ‘survivor’ implies that the psychiatric system is always more harmful than helpful.[21] I will only use ‘survivor’ in this way if an author actively self-identifies as one; otherwise I will use ‘patient’ or ‘service user’. For the most part, when I use ‘survivor’ I do so in the context of sexual violence.[22]

At the heart of the difficulty in navigating these terms is the ongoing lack of consensus as to what mental illness actually is.[23] Despite endless research, we still do not really know what causes or should constitute mental illness: there are fundamental divisions between biomedical disease models of thought, with their belief in the eventual discovery of an

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[20] P. Calloway, and others, ‘Patients and Clients’, *British Journal of Psychiatry,* 178 (2001), 276; Rebecca McGuire-Snieckus, Rosemarie McCabe, and Stefan Priebe, ‘Patient, Client or Service User? A Survey of Patient Preferences of Dress and Address of Six Mental Health Professions’, *Psychiatric Bulletin*, 27 (2003), 305-8.

[21] For more on the c/s/x movement see: Linda J Morrison, *Talking Back to Psychiatry: The Psychiatric Consumer/Survivor/Ex-Patient Movement* (London: Routledge, 2005).

[22] Stacy L. Young and Katheryn C. Maguire, ‘Talking about Sexual Violence’, *Women and Language*, 26. 2 (2003), 40-52.

[23] For a useful overview of the debates surrounding mental illness, its definition, and the role of psychiatry see Rachel Cooper, *Psychiatry and Philosophy of Science* (Acumen: Stocksfield, 2007).

identifiable biological aetiology for mental disorder, to be established through biomarkers and genomic bases,[24] and those who argue that such an approach is reductionist in its prioritisation of brain mechanism and pharmaceutical solution, and who instead call for greater awareness of the individual's social context.[25] Others, without doubting the extent of the individual's emotional pain and distress, view mental illness in terms of socio-historical and linguistic cultural constructs.[26] The debates between disease versus deviance (or better, variation) versus social construction, and the role of psychiatry in making these distinctions, are ongoing.[27] To take arguments surrounding depression as just one example of the polarisation of current debates: Colin Hendrie and Alan Pickles, working from within Institutes of Psychological Sciences and Membranes and Systems Biology respectively, have proposed that the behavioural cluster associated with depression is an evolutionary adaption that can be located in the third ventricle of the brain,[28] whilst, at the other end of the spectrum, noted disability scholar Lennard Davis deconstructs the requirements for a diagnosis of depression according to the fourth edition (2000) of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV) and argues against a disease model.[29] Instead Davis views "depression" as normal reactions to events and circumstances which have been pathologised, claiming that 'we have medicalized a complex phenomenon with many symptoms grouped arbitrarily into a

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[24] Psychiatrist George Engle explained in 1977 how the biomedical model 'assumes diseases to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioral dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioral aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes.' Although dated, it remains a useful definition and highlights many issues still applicable today. George L. Engle, 'The Need for a New Medical Model: A Challenge for Biomedicine', *Science*, 196 (1977), 129-136 (130).

[25] Nikolas Rose 'Neuroscience and the Future for Mental Health?', *Epidemiology and Psychiatric Services*, 25 (2016), 95-100; Allan Horwitz, *Creating Mental Illness* (Chicago: University of Chicago Press, 2002).

[26] Dwight Fee, 'Broken Dialogue: Mental Illness as Discourse and Experience', in *Pathology and the Postmodern: Mental Illness as Discourse and Experience,* ed. Dwight Fee (London: Sage, 2000), pp. 1-17.

[27] Charles Rosenberg, 'Contested Boundaries: Psychiatry, Disease, and Diagnosis', *Perspectives in Biology and Medicine,* 58.1 (2015), 120-37.

[28] Colin A. Hendrie and Andrew R. Pickles, 'Depression as an Evolutionary Adaptation: Anatomical Organisation Around the Third Ventricle', *Medical Hypothesis,* 74 (2010), 735-40.

[29] Lennard J Davis, *The End of Normal: Identity in a Biocultural Era* (Ann Arbour: University of Michigan Press, 2013).

disease entity that we now call "depression."'[30] According to Davis, for depression to count as a disability, it would have to be a disease with a proven biological aetiology, and therefore the psychic distress attributed to it would constitute an impairment, in the disability studies sense of the term.

Historically, mental disability has been marginalised within disability studies, whose focus has tended towards lived experience of somatic impairment. The consequent disconnect between mental health researchers and activists, and disability theorists, emerged from 'the failure of disability theory to adequately conceptualise the experience, phenomenon and constitution of mental health in critical and politicized ways.'[31] This failure is in part due to disability theory's foundations in the social model and the difficulties of applying this model to issues of mental health and distress.[32] The social model of disability differentiates between an individual's impairment and the social construction of disability, which is historically and culturally specific. It shifts the emphasis away from impairment as deficit to analyse how unaccommodating environments render the person disabled.[33] It is contested whether mental illnesses belong under the umbrella of disability due to their fraught relationship with 'impairment', which some scholars and service-users challenge because it reinforces a medical model of mental distress.[34] Whilst cognitive and neurobehavioural conditions, for example autism, are included within disability communities, diagnoses of psychological distress pose

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[30] Ibid., p. 55.

[31] Dan Goodley, 'Is Disability Theory Ready to Engage With Politics of Mental Health?', in *Distress or Disability: Proceedings of a Symposium held at Lancaster University, 15-16 November 2011*, ed. by J. Anderson, B. Sapey, and H. Spandler (Lancaster: Centre for Disability Research, 2012), p. 62.g

[32] E.M. Nabbali, 'A "Mad" Critique of the Social Model of Disability', *International Journal of Diversity in Organizations, Communities, and Nations*, 9.4 (2009), 1-12. Nabbali describes the social model as 'pallid, even empty, when addressing the convoluted systems of psychiatry and mental health' (p. 7). For an argument for a 'disability inclusion' model, extending the social model to include those with mental health issues, see Liz Sayce, *From Psychiatric Patient to Citizen: Overcoming Discrimination and Social Exclusion* (Basingstoke: Macmillan, 2000).

[33] Tom Shakespeare, 'The Social Model of Disability', in *The Disability Studies Reader*, 4th edn, ed. by Davis, pp. 214-21.

[34] Anne Plumb, *Distress Or Disability?: A Discussion Document,* (Manchester: Greater Manchester Coalition of Disabled People, 1994).

more of a classificatory and identity problem. As early as 1996, Peter Beresford et al. summarised the difficulties for people from each side of the debate:

> Many psychiatric system survivors are unwilling to see themselves as disabled. They associate disability with the medicalization of their distress and experience. They reject the biological and genetic explanations of their distress imposed by medical experts. […] Similarly, some disabled people do not feel that psychiatric survivors are disabled, because they do not have a physical impairment or their situation is not permanent. There are also fears and anxieties on both sides of being linked with the negatives that are often associated with the other.[35]

Disability studies, emerging from the disability rights movement, has often tended to disassociate itself from discourses of illness (including chronic or mental) and pain, focusing instead on narratives of independence and empowerment in order to counter ableist assumptions of the value of a disabled life.[36] However, mental health service users, or psychiatric survivors, and members within disability communities can ill afford to ignore certain commonalities of their experiences in order to enforce a separation of their individual and collective identities.[37] This is not to deny the significant differences between the experiences of service users and people with disabilities,[38] but rather recognises the fact that the various disabled and survivor communities are already grouped together under externally imposed definitions, have overlapping experiences of impairment, and have a shared experience of discrimination and oppression.

Scholarship exploring the boundaries between the disciplines of disability studies and mental health has continued more recently with Helen Spandler, Jill Anderson, and Bob

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[35] Peter Beresford, Gloria Gifford, and Chris Harrison, ‘What Has Disability Got to Do With Psychiatric Survivors?’, in *Speaking Our Minds: Personal Experience of Mental Distress and its Consequences,* ed. by J. Reynolds and J. Read (Basingstoke: Macmillan, 1996), pp. 209-14 (p. 209).

[36] An early exception being Colin Barnes, *Exploring the Divide: Illness and Disability* (Leeds: Disability Press, 1996).

[37] Peter Beresford, ‘What Have Madness and Psychiatric System Survivors Got to do with Disability and Disability Studies?’, *Disability and Society,* 15.1 (2000), 167-72.

[38] For example, Plumb emphasises the need for service users/psychiatric system survivors to distinguish themselves from disabled people in the creation of their own distinct identity because of associations of dissent and deviance, which she argues are specific to people with mental health issues (pp. 8-9).

Sapey's edited collection, *Madness, Distress, and the Politics of Disablement.* This text clarifies the key ongoing issues for service users' relationship to disabled communities:

> What are the consequences, for someone experiencing madness or distress, of being categorised as a disabled person? What are the benefits and limitations of adopting a disabled identity? Can disability policies benefit people with mental health problems (and what are some of the barriers preventing them from doing so)? Can the social model of disability apply to madness and distress (and if so, how)? How much can the mental health service user/survivor movement learn from the disabled people's movement, and vice versa? How do mad studies and disability studies connect, if at all? How can disabled people and mental health service users and survivors work together and form alliances to advance our collective interests?[39]

The noticeable presentation of these core issues as questions is indicative of the uncertainty and continuing lack of consensus as to how relationships between mental health and disability might be negotiated and managed. However, as Dan Goodley suggests, there is more to be gained from the 'process of thinking about the interconnection of disability and mental health as possibility rather than complication'.[40] Given that the critical medical humanities is increasingly embracing interdisciplinary methods as standard, such possibilities should be thought of as both natural and necessary; providing opportunity, rather than obstacle.

As with mental illness and disability, the relationship between disability and trauma has been historically fraught. Whilst traumatic events are often the cause of disability, much of the work of disability studies has been undertaken in order to *deconstruct* able-bodied perceptions of disability as being 'inherently traumatic and traumatizing', seeking instead to validate disabled subjectivities and experiences.[41] Recent scholarship, starting with James Berger in 2004, has argued for the benefits of bringing the two fields into contact.[42] Whether they take

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[39] Spandler et al., p. 1.

[40] Goodley, 'Is disability theory ready?' p. 65.

[41] Daniel Morrison and Monica Casper, 'Intersections of Disability Studies and Critical Trauma Studies: A Provocation', *DSQ: Disability Studies Quarterly*, 32.2 (2012), <http://dx.doi.org/10.18061/dsq.v32i2.3189> (para. 3).

[42] James Berger, 'Trauma without Disability, Disability without Trauma: A Disciplinary Divide', *JAC: A Journal of Rhetorics, Culture and Politics*, 24.3 (2004), 563-82.

narrative as a common interest underpinning interdisciplinary research,[43] use embodiment as a platform from which to bring disability and critical trauma studies into dialogue,[44] perform close textual analysis between congenital disability and sexual abuse,[45] or analyse trigger warnings and disclosures as bridges between trauma and disability,[46] critics are realising the fruitfulness of placing disability and trauma in conversation, and the dangers of continuing their arbitrary separation. Margaret Rose Torrell, analysing the integration of a disabled identity politics with traumatic experience in Kenny Fries' *Body, Remember* (1997)*,* argues that disability studies and trauma studies have been separated for so long due to 'the socio-political tendency to devalue a disabled life when it is associated with trauma, pain, and loss.'[47] This tendency, she clearly demonstrates, poses harm to people whose disability was caused by a traumatic event or whose disability causes them pain, whether emotional or physical; subsequently it is not a valid reason to enforce the continued separation of disability and trauma at a disciplinary level:

> While a central aim in literary disability studies has been to work toward disability empowerment, the field's focus on the alternate images and stories of disability may have had the unintentional effect of creating a hierarchy of appropriate representations of disability. The theoretical emphasis on responding to social constructions of disability […] doesn't create a literary or theoretical scene that welcomes a multiplicity of other stories about disability, especially not the stories that intermingle the experience of disability with pain, loss, and trauma.[48]

As is the case with the boundaries and overlaps between mental health and disability, working with an awareness of intersectionality is crucial here, and critics need to continue to find ways

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[43] Valerie Raoul, 'Making Sense of Disease, Disability, and Trauma: Normative and Disruptive Stories', in *Unfitting Stories: Narrative Approaches to Disease, Disability, and Trauma*, ed. by Valerie Roaul et al (Waterloo: Wilfrid Laurier University Press, 2007), pp. 3-11.

[44] Morrison and Casper.

[45] Margaret Rose Torrell, 'Interactions: Disability, Trauma, and the Autobiography', *Life Writing*, 13.1 (2016), 87-103.

[46] Alison Kafer, 'Un/Safe Disclosures: Scenes of Disability and Trauma', *Journal of Literary and Cultural Disability Studies*, 10.1 (2016), 1-20.

[47] Torrell, p. 87.

[48] Torrell, p. 90.

to combine their approaches whilst respecting the subjective experiences of mental health service users, disabled people, and trauma survivors.

Furthermore, it should be noted that the existing discussions of the links between disability and trauma studies are rooted in bodily impairment or wounds, to the detriment of mental distress. Morrison and Casper's article analyses traumatic brain injury and obstetric fistula; Torrell's article explores Fries' congenital disability which affects his legs and feet, causing some loss of mobility, alongside his sexual abuse; and Kafer's discussion focuses on how an arson attack resulted in her being a bilateral-above-the-knee amputee wheelchair-user, although she does also acknowledge the mental and emotional effects of her trauma and the complications they pose to her disabled identity. This thesis will look closer at the commonalities of trauma, disability, and mental illness; and in doing so will provide the addition of the mental and emotional context to these ongoing debates. As such, I will go on to discuss the works of, among others: Lauren Slater who has received diagnoses of major depression, anorexia, border personality disorder, and obsessive compulsive tendencies, and was sexually abused by her mother when she was a child; Elissa Washuta who writes about her experiences of bipolar disorder and rape; Stuart Shorter, a homeless alcoholic and addict with diagnoses of borderline personality disorder and muscular dystrophy, who was the victim of paedophilia; and Katie Green whose recovery from anorexia was entwined with the sexual violence perpetrated by her alternative therapist. The experiences of these people demonstrate the inseparability of trauma – here sexual violence – with entrenched mental health issues, and their texts explore this interrelation in aesthetically challenging ways. Life writing, this thesis will demonstrate, is a medium in which the complicated, entangled issues of mental illness, madness, distress, trauma, and disability can be expressed in ways that do justice to the knottiness and uncertainty of living with and narrating these experiences.

Life writing: narrative and normativity

Life writing entails a particular set of generic expectations and ethical dilemmas.[49] According to Phillipe Lejeune, the reader and writer of autobiography enter a social contract built on the 'identity of name' between the author, the narrator, and the character being talked about; in other words, in contrast to fiction, the author of life writing promises, and the reader expects, that the author, narrator, and subject all refer to the same person.[50] Paul John Eakin, one of the most prolific scholars in autobiography studies, stipulates a further three rules to which, he argues, life writing must adhere: telling the truth, respecting the privacy of others, and, problematically, 'the obligation to display a normative model of personhood'.[51] Throughout the thesis I will showcase the ways in which each of these rules are overly simplistic, prescriptive, and unrealistic, especially in the context of mental health and trauma. Telling the truth initially seems like a straightforward and reasonable expectation of writing that describes itself as autobiographical. Eakin uses James Frey's controversial *A Million Little Pieces* (2003) – a narrative about addiction and recovery that was found to include extensive fabricated content and was subsequently, under much pressure, rebranded as fiction, with the publishing house offering refunds to readers who felt duped – as a prominent example of the consequences of embellishing, fabricating, and lying in life writing.[52] In Chapter One I demonstrate that telling the truth is a much more complicated endeavour than Eakin makes out, particularly in instances of Munchausen's syndrome and repressed memories of sexual violence. To do so I draw upon more recent autobiography theory by Leigh Gilmore that

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[49] For accessible and comprehensive overviews of the definitions, forms, history, and significance of life writing see: Sidonie Smith and Julia Watson, *Reading Autobiography: A Guide for Interpreting Life Narratives* (Minneapolis: University of Minnesota Press, 2001); Ben Yagoda, *Memoir: A History* (New York: Riverhead, 2009); G. Thomas Couser, *Memoir: An Introduction* (Oxford: Oxford University Press, 2012).

[50] Philipe Lejeune, *On Autobiography* (Minneapolis: University of Minnesota Press, 1989), p. 12.

[51] Paul John Eakin, 'Breaking the Rules: The Consequences of Self-Narration', *Biography,* 24.1 (2001), 115-27; Paul John Eakin, *Living Autobiographically: How we Create Identity in Narrative* (London: Cornell University Press, 2008), pp. 17-52.

[52] Eakin, *Living Autobiographically*, pp. 17-22.

unpacks the boundaries between the literary and testimonial to analyse three memoirs by women who self-consciously debate their authority, credibility, and reliability in their narrations of mental illness and distress.[53] To illustrate his second rule, the consequences of implicating others and infringing upon their privacy in your own memoir, Eakin uses the example of Kathryn Harrison's *The Kiss* (1997) — a memoir about her incestuous affair with her father – to demonstrate the consequences of publishing intimate and sensitive material about your family. In Chapter Two I discuss co-produced life writing that emphasises relationality and the impact of mental illness on family members. I analyse the ethical intricacies of a psychologist using case studies of her patients (with their prior consent) to reveal her own history of mental illness and sexual abuse and how a posthumous auto/biography frames incestuous abuse. But it is Eakin's third rule, 'the obligation to display a normative model of personhood' that concerns me most throughout this thesis.

According to Eakin, displaying normalcy entails being able to create and perform a certain kind of narrative. Acts of autobiography are performative: through telling the stories of our lives, we shape those lives; by describing ourselves we construct our-selves.[54] Consequently autobiography (and life writing more generally) is tied up with the creation of a narrative identity. Drawing on scholarship within neuroscience and developmental psychology, Eakin establishes a model of narrative identity that is reliant upon the concept of the 'extended self' – a self that remembers its historical existence and anticipates its future. Eakin argues that narrative formation is a crucial part of the extended self, and that this self is integral to a sense of continuous identity and the production and structure of meaningful experience. Whilst Eakin briefly acknowledges that narrative identity should not be seen as

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[53] Leigh Gilmore, 'Learning from Fakes: Memoir, Confessional Ethics, and the Limits of Genre', in *Contemporary Trauma Narratives: Liminality and the Ethics of Form,* ed. by Susana Onega and Jean-Michel Ganteau (London: Routledge, 2014), pp. 21-35.

[54] Paul John Eakin, *How Our Lives Become Stories: Making Selves* (London: Cornell University Press, 1999).

coextensive with ‘the entire experience of selfhood’,[55] he argues that the extended, narrative self ‘enjoys so central a place in our living that we are conditioned to accept it as the hallmark of functioning identity.’[56] The concepts of ‘normalcy’ and a ‘functional identity’, and their grounding in the ability to perform a model of identity that is located in an extended, diachronic sense of self, is especially problematic in the context of mental illness, psychiatric disability, and distress. The reliance on the role of narrative, and of this particularly circumscribed form of narrative, in terms of being seen to have a “legitimate” identity undermines and marginalises those who cannot, or do not, self-narrate in such an orthodox manner.

Strikingly Eakin turns to the clinical setting to illustrate the consequences of a ‘failure to display normalcy’ through narrative identity construction.[57] Drawing on the work of medical anthropologist Oliver Sacks, Eakin uses Mr Thompson, one of Sacks’ patients, as an example of someone whose ‘impaired self-narration’ results in a ‘damaged identit[y]’.[58] Mr Thompson has Korsakoff’s syndrome, a form of alcohol related brain damage which can entail severe memory loss. Unable to remember for more than a few minutes at a time, Mr Thompson is engaged in a constant process of self (re)invention and therefore, in Eakin’s terms, is ‘severely limit[ed]’ in ‘his ability to articulate a stable narrative account of himself.’ Because identity narratives are performative, judgements about Mr Thompson’s difficulty to adhere to a certain kind of narrative become a judgement about his personhood: ‘the verdict of those for whom we perform is virtually axiomatic: no satisfactory narrative (or no narrative at all), no self.’[59] I agree with Eakin when he writes that people who do not display an extended version of narrative selfhood are frequently judged to be less than complete persons by neurotypical observers, and that this judgement often entails material consequences. However, Eakin’s

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[55] *How Our Lives*, p. 125.
[56] *Living Autobiographically*, p. 48.
[57] Ibid., p. 44.
[58] Ibid., p. 46.
[59] Ibid., p. 44.

writing about narrative identity, normalcy, and the consequences of transgressive narration is limited by its unwillingness to consider alternative ways of narrating and being in the world, and lack of awareness of the work from critical disability studies.

Philosopher Galen Strawson has argued against what he coins the ‘psychological Narrativity thesis’ – the understanding that humans have a natural narrative tendency and see their lives in terms of stories – and the ‘ethical Narrativity thesis’ – that experiencing life in the form of narrative is beneficial and necessary.[60] According to Strawson, ‘it’s just not true that there is only one good way for human beings to experience their being in time. Instead, there are deeply non-Narrative people and there are good ways to live that are deeply non-Narrative.’[61] Strawson outlines two models of selfhood: the diachronic mode, which is equivalent to Eakin’s theorisation of the extended self; and the ‘*episodic’* mode experienced by non-Narrative individuals in which ‘one does not figure oneself, considered as a *self, as something that was there in the (further) past and will be there in the (further) future.’[62] People who live episodically are less likely to interpret their lives in Narrative terms, and Western society’s privileging of narrative can therefore be ‘unnatural’, ‘ruinous’, and ‘a gross hindrance to self-understanding.’[63] Notably, as Woods, has emphasised, Strawson is only concerned with ‘a propensity for Narrativity’, rather than ‘a capacity for narrative’.[64] ‘Whether or not a person is able to tell convincing stories about themselves in ways that respect socially

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[60] Galen Strawson, ‘Against Narrativity’, *Ratio,* 17 (2004), 428-52.

[61] Strawson capitalises ‘Narrative’ in order to denote the specific psychological quality or propensity towards ‘narrative’ (p. 429).

[62] P. 430. Strawson uses the asterisk to distinguish between the two forms of self-existence: one of the self as a whole person, and one of the *self as a mental capacity.

[63] Strawson, p. 447. Following Strawson’s controversial article, there has been a tendency to create a critical narrative in which Eakin, standard-bearer of narrative identity, was revised by Strawson and scholarship subsequently moved on to discussions of post-narrativity. See for example James Phelan, 'Editor's Column: Who's Here? Thoughts on Narrative Identity and Narrative Imperialism', *Narrative,* 13 (2005), 205-10. In fact Eakin published a reply critiquing Strawson, and debates about narrativity are still ongoing. See Paul John Eakin, ‘Narrative Identity and Narrative Imperialism: A Response to Galen Strawson and James Phelan’, *Narrative* 14.2 (2006) 180-87.

[64] Angela Woods, ‘Beyond the Wounded Storyteller: Rethinking Narrativity, Illness and Embodied Self-Experience’ in *Health, Illness and Disease: Philosophical Essays,* ed. by Havi Carel and Rachel Cooper (Newcastle: Acumen, 2012), pp. 113-128 (p. 117).

agreed conventions,' Woods continues 'is for Strawson neither here nor there'.[65] Only focusing on variation between neurotypical people, Strawson neglects to think through the implications of his argument for people with mental disabilities. This is incredibly myopic given the fact that the pressure on individuals to narrate in the way described by Eakin and the vulnerability entailed by transgressing these narrative norms is felt most by people with cognitive and psychiatric disabilities.

It is preposterous to theorise normalcy without acknowledging the seminal work of Davis, who establishes the ways in which 'normalcy is constructed to create the "problem" for the disabled person.'[66] Davis traces how the concept of 'normal' replaced that of the 'ideal', pinning its emergence back to the growing interest in statistics in the mid-19th century. Through analysing the bell curve, 'a symbol of the tyranny of the norm', he argues that the norm can only exist in relation to deviations or extremes and shows how normalcy is a construction produced in particular historical/intellectual/social conditions rather than a self-evident fact. Also working in disability studies, James Overboe argues that expectations of self-narration are ableist in their inability to recognise different modes of communication and failure to acknowledge the personhood of those unable to communicate in an orthodox neurotypical manner, who are then deemed post-persons.[67] Overboe relocates the failure in communication from the person who cannot or does not narrate to the uncomfortableness of the privileged observer, who needs to find more accommodating ways of listening. 'Failing to display normalcy' in life writing may well entail risk, nevertheless such narratives are abundant.

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[65] Ibid.

[66] Lennard J. Davis, 'Introduction: Normality, Power, and Culture', in *The Disability Studies Reader,* ed. Lennard J Davis, 4th edn (Oxon: Routledge, 2013), pp. 1-16 (p. 1). See also *Enforcing Normalcy: Disability, Deafness, and the Body* (London: Verso, 1995); *The End of Normal*.

[67] James Overboe, 'Ableist Limits on Self-narration: The Concept of Post-Personhood', in *Unfitting Stories: Narrative Approaches to Disease, Disability, and Trauma,* ed. Valerie Raoul et al. (Waterloo: Wilfrid Laurier University Press, 2007), pp. 275-84.

Contrary to Eakin's summation that successful life writing is only available to those displaying normalcy, narratives of disability and illness have become the major sub-genre of the recent memoir boom.[68] The growth in the popularity of life writing during the 1990s coincided with the strengthening of disability rights movements in the UK and USA and this combination resulted in a proliferation of memoirs written by those living with various disabilities and illnesses, both physical and mental, ranging from autism to Tourette's, cancer to AIDS. G. Thomas Couser has documented the rise of such memoirs, and drawn attention to alternative forms of life writing including visual representation through portraiture and photography, documentaries, diaries, blogs, and YouTube videos.[69] His principal argument is that life writing, in whichever form, is a particularly accessible means of self-expression for those who occupy a marginalised subject position, and that consequently, it is the primary site of cultural representations of disability today. He further argues that autobiography acts as a method by which disabled writers resist their 'historical subjection' by centring themselves in their own text.[70] In this way, life writing becomes a political act and a platform from which to give voice to positions of non-normalcy; quite the opposite of Eakin's claim. Of course Eakin is not the only one to have made such assumptions. In 2001 Catherine Prendergast, a disability studies scholar, published an article in which she argued that a diagnosis of mental disability, specifically schizophrenia, 'supplants one's position as a rhetor', and that consequently 'to be

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[68] Julie Rak, *Boom! Manufacturing Memoir for the Popular Market* (Ontario: Wilfred Laurier University Press, 2013). A quick Google search reveals endless results of "must read" lists of mental health memoirs including: Rachel Steinman, 'Fourteen insightful memoirs about mental illness and addiction,' *The Writing Cooperative,* 19 October 2018 <https://writingcooperative.com/fourteen-incredible-memoirs-about-mental-illness-and-addiction-1d5d426cb6ab> [accessed 25 May 2019]; Sarah Davis, '50 must-read memoirs of mental illness,' *Bookriot*, 5 August 2019, <https://bookriot.com/2019/05/08/memoirs-about-mental-illness/> [accessed 29 May 2019]; Arianna Rebolini, '31 Books That Will Help You Better Understand Mental Illness And Disorders,' *BuzzFeed,* 6 December 2015 <https://www.buzzfeed.com/ariannarebolini/books-that-will-help-you-better-understand-mental-illness> [accessed 29 May 2019]; Kristian Wilson, '9 Memoirs by Women about Mental Illness to Help you Start Conversations & Better Understand Yourself and Your Loved Ones,' 17 May 2018 < https://www.bustle.com/p/9-memoirs-by-women-about-mental-illness-to-help-you-start-conversations-better-understand-yourself-your-loved-ones-9062471> [accessed 5 August 2019].

[69] G. Thomas Couser, 'Introduction: Disability and Life Writing', *Journal of Literary & Cultural Disability Studies,* 5.3 (2011), 229–42 (pp. 234-37).

[70] G. Thomas Couser, 'Disability, Life Narrative and Representation', in *The Disability Studies Reader,* ed. by Lennard J. Davis, 4th ed. (Oxon: Routledge, 2013), pp. 456-59.

disabled mentally is to be disabled rhetorically'.[71] However, in 2014, Prendergast published a *mea culpa* that recognised the proliferation of memoirs whose authors self-identified as having psychiatric disabilities, the multiple ways that their texts resist subjugation and voice positions of non-normalcy, and acknowledged the fact that authority in these narratives is often 'claimed *because* and not *despite* of the presence of a diagnosis'.[72]

The abundance and popularity of memoirs of illness and disability challenges the normative foundations of autobiography studies. Such memoirs frequently, but by no means always, also challenge generic expectations through formal experimentation and innovation. Writing about 'genres of crisis' in contemporary autobiography, Susanna Egan analyses the reflexive practices of narratives of terminal illness.[73] Shifting her attention from the product of autobiography to its processes, Egan explores the interactions between selves, contributors, readers and writers, and among genres of autobiography. I will return to Egan's work, particularly her emphases on dialogism, relationality, and instability, in my discussion of co-produced texts in Chapter Two. Investigating the textual aesthetics of trauma in autobiography, Gilmore interrogates the links between trauma, memory, testimony, self-representation, and representativeness.[74] She analyses a series of narratives that test the limits of what is deemed possible within autobiography to argue that 'an engagement with autobiography […] is both a recognizable and significant feature of texts that do not readily conform to the genre of autobiography.'[75] Like Egan, Gilmore notices that texts that do not

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[71] Catherine Prendergast, 'On the Rhetorics of Mental Disability', in *Embodied Rhetorics: Disability in Language and Culture*, ed. by James Wilson and Cynthia Lewiecki-Wilson (Carbondale: South Illinois University Press, 2001), pp. 45-60.

[72] Catherine Prendergast, 'Mental Disability and Rhetoricity Retold', in *Changing Social Attitudes Towards Disability: Perspectives from Historical, Cultural and Educational Studies*, ed. by David Bolt (Abingdon, Oxon: Routledge, 2014), pp. 60-67 (p. 61; original italics).

[73] Susanna Egan, *Mirror Talk: Genres of Crisis in Contemporary Autobiography* (London: University of North Carolina Press, 1999).

[74] Leigh Gilmore, *The Limits of Autobiography: Trauma and Testimony* (New York: Cornell University Press, 2001).

[75] Ibid., p, 14. However, I question Gilmore's inclusion of Kay Redfield Jamison's *An Unquiet Mind,* Susanna Kaysen's *Girl, Interrupted* (1993), Lauren Slater's *Prozac Diary* (1998), and William Styron's

adhere to the prescribed and out-dated expectations of what autobiography is, what it can do, and what it looks like are particularly self-conscious about their deviance. In this thesis I will extend Egan and Gilmore's observations by arguing that memoirists of mental illness are even more self-conscious about their narrative transgressions (whether in form or content) because of their ongoing experiences contending with their own perceived lack of reliability and authority.

Hilary Clark and Brendan Stone have argued that mental illness and madness pose specific challenges to narrative and narrative identity. Writing specifically about depression, Clark argues that acknowledging narrative's limits is an unavoidable ethical issue and that 'narrative is most authentic as it approaches, or reaches, its limits'; although I hesitate in agreeing with Clark here because authenticity is always a problematic metric of life writing, particularly about illness and distress.[76] Linking madness to trauma theory to explore the 'unspeakable' nature of 'limit experience', Stone argues that, if certain experiences of mental distress are beyond expression, concomitantly they must also be beyond narration.[77] He further argues that imposing order, sense, reason, progression, linearity, and resolution on the experience of madness, in order to make it into a contained and accessible narrative, renders the narration of the experience inauthentic given that madness, due to its very nature, defies the organising principles of narrative. However, this should not, and, as I will demonstrate, has not, prevented people with madness or mental illness from accessing life writing as a means of self-expression. So as not to invalidate mad people as subjects, Stone elsewhere emphasises the need to reconstitute the concept of narrative identity in relation to the momentary and fragmentary, and separate it from the assumption that self-narrative has to be 'complete' or

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Darkness Visible (1989) amongst her catalogue of recent trauma narratives. Jamison, in particular, never conceives of her manic depression as traumatic.

[76] Hilary Clark, 'Introduction', in *Depression and Narrative: Telling the Dark,* ed. by Hilary Clark (New York: SUNY Press, 2008), pp. 15-28 (p. 9).

[77] Brendan Stone, 'Towards a Writing without Power: Notes on the Narration of Madness', *Auto/Biography*, 14.1 (2004), 16-33.

‘conclusive’.[78] This reconfiguration of narrative identity as fragmentary, episodic, and inconclusive pre-empts much of the contemporary work within the literary critical medical humanities on illness narratives and creates a space, I will argue, for literary innovation in the expression of mental illness. Such innovation has been the guiding principle behind the selection of texts in this thesis. For example, the way Slater maintains uncertainty by refusing to tell her reader whether she actually has epilepsy or whether it is a purely metaphorical vehicle to convey histories of distress and abuse in *Lying*; the way Washuta collates a series of interlinked essays, each with a different structure and format, to grapple with the actualities of her diagnosis and the repercussions of rape; the way Masters intersperses his auto/biography with cartoons and transcripts in order to include Stuart in the text’s form, as well as its content; and, the way glimpses, moments, fragments and episodes are the literal foundations of the graphic memoirs of the final chapter. Through such textual experimentations, I explore the ways in which ‘the limit’ is not simply an inevitability of mental health discourse, but is mobilised as a strategic, transgressive, and, frequently, antagonistic tool which embraces the liminal and its inherent messiness.

Reading illness narratives: narrative medicine and literary studies

Historically there has been a problematic relationship between medical humanities approaches to reading illness narratives and the literary. In the first wave of the medical humanities, work on illness narratives was primarily interested in their transformative potential and therapeutic application,[79] and the benefits of using memoirs as part of a pedagogical strategy in health care training.[80] In her influential text *Narrative Medicine:*

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[78] Brendan Stone, ‘Why Fiction Matters to Madness’, in *Narrative and Fiction: An Interdisciplinary Approach*, ed. by David Robinson and others (Huddersfield: University of Huddersfield, 2008), pp. 71-77.

[79] Arthur Kleinman, *The Illness Narratives: Suffering, Healing and the Human Condition* (New York: Basic Books, 1988).

[80] Rita Charon and others, ‘Literature and Medicine: Contributions to Clinical Practice’, *Annals of Internal Medicine*, 122.8 (1995), 599-606.

Honoring the Stories of Illness (2006), Rita Charon argues that clinical practice can be strengthened and made more empathetic by the knowledge of and ability to interpret stories, and subsequently calls for all practitioners to be trained in what she calls 'narrative competence'.[81] Proponents of 'narrative medicine' argue that patient narratives encourage empathy by providing clinicians with insight into the subjective experience of illness; give the patient a means by which to come to terms with their experiences; and facilitate communication between practitioner and patient. Specifically in the context of psychiatric training, Paul Crawford and Charley Baker argue that reading fiction and autobiography enhances education because it helps to counterbalance the 'increasing biomedical dominance in psychiatry' and, supposedly, enables clinicians to 'develop deeper empathic understanding' of experiences of mental illness.[82] Here we can see the medical humanities being cast in the two circumscribed roles – 'supportive friend' and disruptive 'counterbalance' to biomedicine – outlined above by Viney, Callard and Woods.

The readings of texts produced within narrative medicine, based on approaches to narrative developed within the fields of sociology and psychology, use life stories as case studies from which to trace trajectories of illness and recovery, and establish categories of patient experience. Arthur Frank's seminal *The Wounded Storyteller* is the most influential example of such work. Frank famously argues that telling stories is a means for a patient to reclaim their sense of self in the midst of the destabilising uncertainty of illness – a state of being that he coins 'narrative wreckage'.[83] Frank argues that illness demands narrative not just in the very literal sense of needing to inform others about symptoms, tests, results, prognosis, and so on, but also in order to '*repair* the damage that illness has done to the ill person's sense

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[81] Rita Charon, *Narrative Medicine: Honouring the Stories of Illness* (Oxford: Oxford University Press, 2006).

[82] Paul Crawford and Charley Baker, 'Literature and Madness: Fiction for Students and Professionals', *Journal of Medical Humanities*, 30 (2009), 237-51.

[83] Arthur Frank, *The Wounded Storyteller: Body, Illness and Ethics*, 2nd edn (London: The University of Chicago Press, 2013), pg. 68.

of where she is in life, and where she may be going'.[84] He continues to categorise the ensuing narratives as belonging to three templates: 'quest', 'restitution', and/or 'chaos'. The quest narrative sees the period of illness as a quasi-spiritual journey from which the patient will undergo a transformation and gain new self-knowledge. In the restitution narrative the patient has been, or is pre-empting being, restored to their previous state of health. When told retrospectively this narrative becomes one of overcoming, and the period of illness is often interpreted as an interruption to an otherwise linear, coherent life narrative.[85] The chaos narrative is a non-plot in which the patient is in a state of narrative wreckage, and cannot imagine a return to health. It cannot be verbalised and told as to do so would imply that the teller has already gained a sense of critical distance from the chaos; instead this narrative can only be lived. Such non-narratives are, according to Frank, characterised by their lack of sequence, order, and causality; Eakin's example of Mr Thompson would belong in this category. Elsewhere, in a similar vein, Anne Hunsaker Hawkins argues that illness narratives, or, as she calls them, pathographies, counter the depersonalisation and objectification of the medical chart.[86] She also categorises them, but according to authorial intent: 'didactic pathographies' wish to help others by explaining their own experiences of a particular illness and course of treatment; 'angry pathographies' write back to unethical practices and a lack of care; the 'alternatives pathography' seeks out non-traditional approaches to treatment; and 'ecopathographies' situate experiences of illness in wider environmental, political, or cultural contexts. For scholars trained in literary studies, these readings of texts are frustrating because their disproportionate emphases on tracing templates, establishing categories, gaining insight, and fostering empathy flattens the knotty work that narrative, and scholarship on it, can undertake.

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[84] Ibid., pp. 52-53 (original emphasis).

[85] Given the emphasis on chronological temporality, linearity and coherence are often mistakenly conflated in critical discussions of illness narratives.

[86] Anne Hunsaker Hawkins, 'Pathography: Patient Narratives of Illness', *Western Journal of Medicine*, 171.2 (1999), 127-29.

In *Illness as Narrative* (2012) Ann Jurecic traces a history of the cultural emergence of illness narratives, from their absence during the influenza outbreak in the wake of World War One to their proliferation during the 1980s HIV/AIDS crisis, and draws attention to the problems they raise for criticism.[87] She argues that literary scholarship within the academy has maintained an arbitrary and absolute divide between everyday experience and critical engagement in its distaste for, and distrust of, such emotional narratives, which are often snubbed as 'misery memoirs' or 'victim art'. Literary scholars, Jurecic asserts, in their valuation of 'complexity over utility',[88] lack an appropriate critical paradigm through which to react to and analyse personal accounts of pain and suffering. Whilst generally I agree with Jurecic's summation of literary studies' noticeable lack of engagement with illness narratives, it is important to highlight a few exceptions to this trend: the work of Egan, Clark, and Stone outlined above, and Kathlyn Conway.[89] Criticising the deficit of scholarship on illness narratives, Jurecic asks 'how can literary criticism productively engage with the new genre of the illness memoir?' She argues that critics have become too reliant on Paul de Ricoeur's 'hermeneutics of suspicion', and subsequently calls for scholars in literary studies to reclaim their 'willingness to listen' in order to better attend to autobiographical narratives of illness.[90]

Faced with literary studies' negligence of illness narratives, Jurecic turns to the work undertaken in what is now recognised as the first wave of the medical humanities. Jurecic acknowledges that for critics with humanities training, 'the idea of trusting a narrative to provide access to the experience of another person indicates a naïve understanding of how such texts function'.[91] And yet, in her eagerness to demonstrate the shortcomings, or absence, of a literary studies approach to illness narratives, Jurecic – praising of the work of Charon,

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[87] Ann Jurecic, *Illness as Narrative* (Pittsburgh: University of Pittsburgh Press, 2012).
[88] Ibid., p. 12.
[89] Kathlyn Conway, *Illness and the Limits of Expression* (Ann Arbour: University of Michigan Press, 2007).
[90] Jurecic, pp. 3-4.
[91] Jurecic, p. 3.

Frank, and Hawkins – legitimises the narrow version of reading that narrative medicine valorises:

> The theories of narrative set forth in the work of Charon, Frank, and Hawkins respect the irreducibility of the writer's body. The experience of illness, their work demonstrates, finds expression in recognizable forms, yet the familiarity of the narrative patterns does not detract from the urgent work these narratives perform for the writers.[92]

I contest that the work of Frank and others respects the 'irreducibility' of the writer's body or selfhood. The simplification of individual, nuanced accounts of illness to plot-based templates unavoidably reduces the experience of illness and the complexities of its expression to its barest bones. The cataloguing of illness narratives may serve a use in creating an index of texts from which to perform vast literature reviews, but reading accounts of illness primarily for such a purpose undermines the potential of such literature. Furthermore, such typologies tend to prioritise and value certain kinds of narrative, namely those which demonstrate cohesion, linearity, and resolution, which are inaccessible or unfavourable to many people, especially those with chronic and terminal conditions. Additionally, as Lars-Christer Hydén has noted, Frank's typologies create the expectation of 'a meta-narrative of illness from "chaos" to "quest."'[93] Noticeably, for all that this tradition of narrative medicine is foundational in the development of medical humanities as a field, its exponents have little, if any, critical expertise in narrative per se, and such research rarely is able to match the aesthetic and formal sophistication inherent in many illness narratives. If we are to practise a scholarship that can genuinely engage with the complexities and entanglements of illness narratives, then we require more subtle and nuanced ways of critical telling.

Much has changed in the years since *Illness as Narrative* was published. Literary scholars have awoken to the potential of illness narratives and analyses of the limitations of narrative medicine, and its narrow configuration of narrative in particular, are now commonplace in the critical medical humanities; indeed they have become characteristic of

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[92] Ibid., p. 15.

[93] Lars-Christer Hydén, 'Illness and Narrative', *Sociology of Health and Illness*, 19 (1997), 48-69 (p. 54).

the field moving into its second wave. The most notable criticism of Frank's work comes from Woods who, mobilising Strawson's critique of the ethical Narrativity thesis, challenges the assumption that the self is naturally articulated through narrative and that the creation of narrative is the only, or most appropriate, method by which to respond to the effects of illness. She also draws attention to the subsequent lack of provision for those who cannot self-narrate in a typical manner.[94] Woods does not suggest that scholars do away with narrative completely, but that we look more closely at its limits and recognise its non-universality.[95] Woods' call to look beyond narrative prompted critics to reassess what narrative could look like, the work it could perform, which forms of narrative have been valorised, and their own modes of analysis.[96] Elsewhere, Whitehead criticises Charon's work for presuming narrative interpretation to be 'essentially humanizing' and for the 'additive' role that it attributes to the humanities, which are seen as instrumental, enhancing the pre-existing work of the practitioner, rather than doing fundamental work in and of their own right.[97] Whitehead continues to provide an example of the kind of work that a literary perspective might bring to studies of illness narratives. Analysing Jackie Stacey's *Teratologies: A Cultural Study of Cancer* (1997), Whitehead emphasises Stacey's resistance to meaning making and the impulse to assert mastery over her illness narrative. Instead, Stacey's willingness to dwell in moments of chaos and uncertainty, Whitehead argues, demonstrates that there are many aspects of illness that 'do not readily conform to conventional narrative modes'.[98] Praising Stacey's blend of autobiography and theory in her pathography, Whitehead also calls for scholars within the medical humanities to have a more expansive sense of what the literary might look like, paying

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[94] Woods, 'Beyond the Wounded Storyteller', p. 123.

[95] Angela Woods, 'The Limits of Narrative: Provocations for the Medical Humanities', *Medical Humanities*, 37 (2011), 73-78.

[96] Or, in some cases, to defend narrative; see Claire Charlotte McKechnie, 'Anxieties of Communication: The Limits of Narrative in the Medical Humanities', *Medical Humanities*, 40 (2014), 119-24.

[97] Anne Whitehead, 'The Medical Humanities: A Literary Perspective', in *Medicine, Health, and the Arts: Approaches to the Medical Humanities*, ed. by Victoria Bates, Alan Bleakley, and Sam Goodman (London: Routledge, 2014), pp. 107-27.

[98] Ibid., p. 115.

attention to the permeability of the boundaries of genre(s), particularly those that are fragmented or incorporate mixed-media narrative modes.

These critiques of narrative medicine invigorated literary scholars working within a newly critical medical humanities to engage with illness narratives. The second wave of the medical humanities, Whitehead and Woods stipulate in the introduction to *The Edinburgh Companion*, marks a move away from the mode of reading a literary text 'as a straightforward representation of and mode of access to the experience of illness'.[99] Instead, the 'literary critical medical humanities' examines 'in detail the aesthetic and narrative strategies through which literary texts model cognitive and affective processes'.[100] Two recent examples of scholarship, by Stella Bolaki and Sara Wasson, indicate the kinds of work that literary studies will perform in this newly critical space. In her monograph *Illness as Many Narratives* (2017), Bolaki brings together illness narratives from various genres – including photography, artist books, performance art, film, and animation – to 'create a more inclusive illness narrative canon' that celebrates multiplicity and enables her to analyse the polyvalent work that such diverse narratives do.[101] Hesitant to take up Woods' invitation to go beyond narrative, Bolaki advocates instead that 'there is room to challenge and expand narrative's conception and role within the medical humanities'.[102] Actively situating herself within the critical medical humanities, Bolaki embraces the interdisciplinary entanglement outlined earlier in this introduction, arguing that one of the

> central task[s] for the critical medical humanities is to underline the limitations of narrow disciplinary approaches to illness narrative – that is to show how rigid interpretations in both the arts/humanities and social sciences fail to address the kind of *work* that these narratives do.[103]

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[99] Whitehead and Woods, 'Introduction', p. 19.

[100] Ibid., p. 17.

[101] Stella Bolaki, *Illness as Many Narratives: Arts, Medicine and Culture* (Edinburgh: Edinburgh University Press, 2017).

[102] Ibid., p. 6.

[103] Ibid., p. 10 (original emphasis).

To achieve this, Bolaki argues, scholars need to continue 'actively fashion[ing]' tools and methodologies that better attend to the diverse personal, cultural, and political work performed by illness narratives.[104] Working in the context of chronic pain, Wasson similarly argues that certain illness experiences require a 'reading practice less concerned with narrative coherence or self-authorship' or the arc of a text, and that is instead better attuned to the value of the fragmentary, episodic, momentary, and glimpsed. Such language speaks back to Stone's work on madness memoirs, which anticipated this second wave of medical humanities scholarship with its early emphasis on reconfiguring narrative identity.[105] Wasson further argues that chronic pain necessitates reconsiderations of conventions of narrative temporality and teleology. Frank's quest narrative typology, Wasson critiques, requires the protagonist to orient themselves in relation to an ameliorated future, which is inaccessible to those suffering with chronic pain, and, as I will demonstrate in this thesis, for many experiencing mental distress.

The most recent critique of culturally dominant narratives about illness comes from Woods, Akiko Hart, and Spandler who theorise the Recovery Narrative as a particular instance of circumscribed storytelling about illness and distress.[106] Woods, Hart, and Spandler establish the Recovery Narrative (capitalised to distinguish it as a category of narrative as opposed to referring to any individual testimony about recovery) as a genre; they do not analyse the thematic content of any individual accounts of recovery from mental illness or distress, but analyse the Recovery Narrative as a particular kind of story that is produced, commissioned, performed, and mobilised in certain sites (including mental health services, charity campaigns, conferences, policy making) and consequently shares structural similarities. Recovery

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[104] Ibid., p. 12.

[105] Sara Wasson, 'Before Narrative: Episodic Reading and Representations of Chronic Pain', *Medical Humanities*, 44 (2018), 1-7.

[106] Angela Woods, Akiko Hart, and Helen Spandler, 'The Recovery Narrative: Politics and Possibilities of a Genre,' *Culture, Medicine, and Psychiatry*, (2019), 1-27 < https://doi.org/10.1007/s11013-019-09623-y > [accessed 23 August 2019].

Narratives are short '(2-5 min, or 250-375 words), have an obvious beginning, middle and end, and use clear and accessible language'.[107] Frequently structured as a 'journey', their chief characteristics are their joint emphases on insight and inspiration.[108] Woods, Hart, and Spandler's critique of the Recovery Narrative as genre does not undermine the achievements of any individual's testimony, but critiques the forces and frameworks that dictate it and problematise its dominance. They also call attention to the marginalisation of narratives of mental illness, madness, and distress that fail to adhere to the Recovery Narrative's strict generic expectations. Through their critique of the Recovery Narrative, Woods, Hart, and Spandler hope to encourage engagement with other kinds of stories and ways of telling which embrace 'silence, ambiguity, contradictions and uncertainty' as opposed to the 'fixity of more conventional and constrained illness narratives and patient identities'.[109]

Unlike the rigidity that typifies the Recovery Narrative, the texts in this thesis are characterised by the diversity of subject position and experience of illness, as well as their formal experimentation. Life writing, I will demonstrate, is a space that allows for more nuanced and complex interactions with the notion of recovery, unlike the performed narrative, which is the focus of Woods, Hart, and Spandler's paper. All of the narratives that I will explore frustrate the notion of recovery, whether that be as a result of their inconclusive and uncertain attitude towards their illness experience and its trajectory; writing while still experiencing mental distress (rather than retrospectively); disagreements between contributors as to the subject's mental states; writing about a subject who died during the narrative's production; writing about mental illnesses that are chronic; or exemplifying the dangers that arise from the burden to be recovered. My readings of the texts' dynamism are also informed by the work of Bolaki and Wasson. Bolaki's analysis of narratives from multiple genres enriches her discussion

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[107] Ibid., p. 8.

[108] For more on patient testimony performing insight see: Angela Woods, 'Rethinking "Patient Testimony" in the Medical Humanities: The Case of Schizophrenia Bulletin's First Person Accounts', *Journal of Literature and Science*, 6.1 (2012), 38-54.

[109] Woods, Hart, and Spandler, p. 19.

of the work that illness narratives perform. In this thesis I analyse both prose and graphic representations of mental illness and distress. The comics form extends my discussion of multimodality and relationality, as well as highlighting the embodied nature of mental illness and the tensions between subject, narrator, and writer, which are easily obscured in prose narratives. Wasson's emphasis on the momentary and episodic in the context of chronic pain translates easily to my discussion of mental illness in life writing, particularly in my analysis of vignettes and comics. It is noticeable that all of the critical work outlined above is unmistakeably feminist, and yet none of these interventions explicitly identify as such. It is also noteworthy that in a recent, wide-ranging special issue on 'Feminist Encounters with the Medical Humanities' there was no discussion of mental illness, madness, or psychological distress.[110] Consequently, my focus on mental illness, coupled with my explicitly feminist methodology, build on and extend current discussions of illness and narrative in the second wave of the critical medical humanities.

Diagnosis and counter-diagnosis: modes of reading and resisting

Fashioning modes of reading that are less preoccupied with coherence and narrative resolution, and more attentive to the fragmentary, momentary, ambivalent, and episodic is particularly crucial when engaging with life writing about mental illness, madness, and distress. Reading has the capacity, even tendency, to be a diagnostic enterprise. In the clinical context diagnosis is, according to medical anthropologist Annemarie Jutel, 'the medical reading of […] symptoms: interpreting and organizing them according to models and patterns recognized by the profession'.[111] When a patient visits a doctor, Jutel continues, their stories 'are

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[110] Sherri L. Foster and Jana Funke, 'Feminist Encounters with the Medical Humanities', *Feminist Encounters: A Journal of Critical Studies in Culture and Politics*, 2.2, 14 (2018), 1-6 < https://doi.org/10.20897/femenc/3882> [accessed 25 August 2019].

[111] Annemarie Goldstein Jutel, *Putting a Name to it: Diagnosis in Contemporary Society* (Baltimore: John Hopkins University Press, 2011), p. 64. Jutel has recently extended her work on diagnosis in a new monograph *Diagnosis: Truths and Tales* (London: University of Toronto Press, 2019).

transformed into medical accounts upon their telling. The doctor interrogates, interprets, and retells the story, establishing the "plot" and a diagnostic organization'.[112] Jutel's emphasis on narrative interpretation and organisation according to models, patterns, and plots is reminiscent of the mode of reading adopted by narrative medicine practitioners, in which illness narratives are read to gain insight into patient experience and are categorised according to recognised templates and trajectories. In literary studies, Torrell warns that 'the trauma studies practitioner may act somewhat like a diagnosing doctor, placing the autobiographer in the position of patient',[113] and Elizabeth Donaldson, whose work I will engage with in more detail in the next chapter, similarly emphasises that

> there is a sense in which all illness narratives are forms of a clinical encounter, in which the writer is the patient who presents and performs her symptoms for the reader. If the reader's approach to the text is heavily structured by the diagnostic gaze, then the narrative can become the equivalent of a case study, read primarily to provide information about an illness.[114]

Such readings, as I have already begun to indicate in my analysis of the limitations of Frank, Hawkins, and Charon's approaches to narrative, do a disservice to the nuance and complexity of life writing about illness. Furthermore, readings motivated by a diagnostic endeavour are especially inappropriate and potentially damaging in the context of mental illness and madness, in which diagnoses often have fraught histories.

Psychiatric diagnoses are frequently contested both within the medical profession and by service users, as exemplified by the anti-psychiatry movement and the growing critical emphasis on service-user led research. Despite this controversy, the biomedical model is accepted in the United States where it underpins the *DSM,* the handbook of psychiatric diagnosis. The *DSM* (generally and the most recent *DSM*-5) has been frequently criticised for its standardised diagnoses, symptom-based approach, neglect of psychosocial factors, and for

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[112] Jutel, *Putting a Name to it*, p. 65.

[113] Torrell, p. 92.

[114] Elizabeth J. Donaldson, 'Lauren Slater's Lying: Metaphorical Memoir and Pathological Pathography', *Gender Forum,* 26 (2009), <http://www.genderforum.org/print/issues/literature-and-medicine-ii/lauren-slaters-lying/?fontsize=2> [accessed 24 June 15].

pathologizing everyday behaviour.[115] Taking a stronger stance against the *DSM*, and the authority behind it, psychiatric survivors Anne Wilson and Peter Beresford write that

> having been on the receiving end of this diagnostic process, the categorization and classification of our mental and emotional distress has served no useful purpose. Both of us have experienced psychiatrists' enhanced interest in some aspects of our distress and the "playing down" of other aspects in order that it, or we, conform to a specific diagnostic category and prescribed "treatment". Our experience of mental and emotional distress does not fit neatly with psychiatry's classificatory system.[116]

Wilson and Beresford illustrate the frustration of being moulded to fit standardised psychiatric diagnostic categories: the individuality of their experience is ignored in order to neatly, if falsely, categorise them; consequently, any ensuing treatment is, ironically, less likely to ameliorate their distress. Furthermore, those diagnoses, which feel untrue to their experiences, are indelible: '*once we have been diagnosed, "our diagnosis" is recorded (in perpetuity) in our medical and psychiatric records*'.[117] Dissatisfied with psychiatry's 'diagnostic empire', both call for the development of a social model of mental health developed by service users/survivors, akin to that of the social model of disability.[118]

The work of survivor scholar Jasna Russo is also motivated by her own experiences 'of being *interpreted* instead of heard and *responded to* in the course of psychiatric treatment'.[119] Russo critiques the ways in which illness narratives of people with psychiatric diagnoses – whether published first-person accounts or transcripts of interviews – are processed and used in psychiatric and mental health research in the UK and USA. Russo argues that the division of

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[115] Herb Kutchins and Stuart A. Kirk, *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders* (London: Constable, 1999); Peter Conrad, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (Baltimore: John Hopkins University Press, 2008); Allen Frances, M.D., *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (William Morrow, 2013); Ian Hacking, 'Lost in the Forest', *London Review of Books*, 35.15 (2013), 7-8.

[116] Anne Wilson and Peter Beresford, 'Madness, Distress, and Postmodernity: Putting the Record Straight', in *Disability/Postmodernity: Embodying Disability Theory*, ed. by Mairian Corker and Tom Shakespeare (London: Continuum, 2002), pp. 143-57 (p. 146).

[117] Ibid., p. 147 (original emphasis).

[118] Ibid., pp. 143-45.

[119] Jasna Russo, 'In Dialogue with Conventional Narrative Research in Psychiatry and Mental Health', *Philosophy, Psychiatry, & Psychology*, 23.3/4 (2016), 215-28 (p. 216; original emphasis).

labour between participants, who provide their stories, and 'experts', who analyse them, treats people with experiences of mental illness or madness 'as data sources' and 'perpetuate[s] the role and power divisions central to psychiatric treatment'.[120] Like Russo, Jill Magi, Nev Jones, and Timothy Kelly call for an end to 'the ongoing scholarly colonisation of mad discourse' in which 'the patient is there to provide narrative and observational data-points'.[121] Drawing further parallels between psychiatric treatment and narrative research, Russo points to the 'inequality of power to name and define' central to both practices and argues that the power structures of 'conventional narrative research' renders it epistemically violent.[122] Because psychiatric survivors have already 'undergone classification and interpretation of their experiences' when receiving their psychiatric diagnoses, Russo questions 'whether anyone has the right to asses those authors again and to impose any kind of classification on their stories'.[123]

Unsurprisingly, then, Russo takes issue with the kinds of classificatory readings frequently undertaken within psychology, sociology, and narrative medicine. In particular she cites Alexandra Adame and Gail Hornstein's taxonomy of ten published accounts of mental illness and madness (which problematically includes Temple Grandin's *Thinking in Pictures* about her experiences of autism) as an example of ethically unsound research.[124] Adame and Hornstein's emphasis on gaining insight from their selection of narrative accounts and the usefulness of life writing in clinical training and practice speak back to the tenets of narrative medicine. Describing published first-person narratives of madness as 'a practically untapped resource of first-hand data on "mental illness"' they seek to establish a 'typology of narratives

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[120] Ibid. In Chapter Two, I will analyse such labour divisions and power dynamics in the context of collaborative life writing.

[121] Jill Magi, Nev Jones, and Timothy Kelly, 'How Are/Our Work: "What, if Anything, is the Use of Any of This?"' in *The Edinburgh Companion to Medical Humanities*, ed. by Whitehead and Woods, pp. 136-52

[122] Ibid., p. 217.

[123] Ibid., p. 220.

[124] Alexandra L. Adame and Gail A. Hornstein, 'Representing Madness: How are Subjective Experiences of Emotional Distress Presented in First-Person Accounts?', *The Humanistic Psychologist*, 34.2 (2006), 135-58.

of emotional distress' by analysing the 'subjective experience, narrative structure, voice, and purpose' of each account.[125] Using a 'set of questions for each narrative characteristic, [they] analysed each narrative and pulled out quotes that they felt "answered" each question', then created 'profiles' of each of the accounts in order to 'identify common themes and patterns'.[126] It is worth noting that Adame and Hornstein are by no means the only researchers to approach narratives in this manner.[127] Like Russo, I find this method of engaging with life writing about madness and mental illness jarring and detrimental.[128] The concept of engaging with life writing in this way – using a text as a data source from which to extract answers to ready-made questions – is, from a literary studies perspective, baffling. Notably, Russo explicitly states that life writing and literary studies are outside of the scope of her article. I wonder whether she feels that literary studies' approaches to life writing about mental illness and madness are equally appropriative and harmful. In this thesis I hope to demonstrate that literary studies, especially when it works with an interdisciplinary awareness of the critical medical humanities, critical disability studies, and critical trauma studies can remain ethically engaged while being attentive to experiences of mental illness, madness, and distress in life writing.

One example of the ways in which literary studies, working with disability studies, can achieve this is through calling attention to practices of reading narratives about and by people with psychiatric disabilities. Price, in combining a disability studies approach with a critical discourse analysis methodology, develops the concept of *counter-diagnosis* as a means by which to explore the dynamics of illness, power, and personhood in illness narratives.[129] Price defines counter-diagnosis as a strategy with which those with mental disabilities use language

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[125] Ibid., pp. 137-41.

[126] Ibid., pp. 141-42.

[127] Russo cites a further six studies, which all, to varying degrees, exemplify this methodology.

[128] Russo, p. 221.

[129] Margaret Price, '"Her Pronouns Wax and Wane": Psychosocial Disability, Autobiography, and Counter-Diagnosis', *Journal of Literary & Cultural Disability Studies*, 3 (2009), 11-33.

in their autobiographies to write back to biomedical logic, ‘to subvert the diagnostic urge to “explain” a disabled mind’.[130] This ‘appetite for diagnosis’, or diagnostic urge, is the reader’s desire for neatness, for definition, and certainty; to find out what is really *wrong* with the autobiographical narrator in order that there might be a way to fix it.[131] Rather than indulging this urge, counter-diagnosis complicates and entangles it in order to demonstrate the messiness and uncertainty of mental illness, and in doing so reminds the reader that the ubiquity of restitution and triumph narrative simplifies, and frequently censors, the intricate and muddled experiences of illness and disability. Price explores the counter-diagnostic by performing a micro-analysis of discourse features, focusing specifically on the uses of pronouns as windows into larger dynamics of power. As I demonstrate in this thesis, her methodology can be expanded to include a wider range of literary devices deployed by writers in their construction of difference and shaping of narrative.

In the counter-diagnostic mode of writing, writers capitalise upon the difficulties that psychiatric disability poses to narration to create texts that pay attention to complexity and uncertainty. As such they turn what might appear as limitation into opportunity and construct ‘forms of authority that draw upon, rather than “overcome,” their disabilities’.[132] Consequently, they produce texts that are ‘strategically disorganised’ and ‘*creatively incoherent*.’ Rather than their incoherence, or I suggest, anti-coherence, being a shortcoming of the narrative, it is purposefully constructed to translate the experience of psychological distress into form; thus anti-coherence is ‘turned into strategic advantage rather than accommodated as impairment’.[133] Price’s critical discourse analysis, focusing on the disruptive complications of the first, second, and third person pronouns in her selected texts, establishes the fruitfulness of counter-diagnosis as a mode of reading. More recently counter-diagnosis

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[130] Ibid., p. 17.
[131] Ibid., p. 27.
[132] Ibid., pp. 12-13.
[133] Ibid., p. 19.

has been evident as a guiding principle shaping the structure and content of academic work. A politicised turn towards strategic disorganisation and creative incoherence fittingly describes Magi, Jones, and Kelly's mad studies intervention in *The Edinburgh Companion to Medical Humanities*. Their chapter, 'How Are/Our Work: "What, if Anything, is the Use of Any of This?', is a polyvocal piece of scholarship that closes the distance between those who hear voices and those who study psychosis. Mobilising language, punctuation, typography, and page layout, it interweaves the personal, political, theoretical, lyrical, and critical while reflecting on how to undertake mad work and what such work can look like. Demonstrating the same 'preoccupation with nuance and reflexivity' present in the texts that follow, Magi, Jones, and Kelly find that 'it is no longer possible to keep on addressing imagined readers with the same language sequences, spacing, syntax, thesis and conclusion structure that had often trapped [them]'.[134] Instead they cut and paste, juxtapose and entangle to create an alternative mode that enacts the disruption they seek in mad studies scholarship. Such counter-diagnostic experimentation and wilful refusal to be contained within claustrophobic forms runs throughout this thesis.

In the readings of the texts that follow, I analyse the ways in which writers interrogate and critique their diagnoses before either deciding to work with and around them, recontextualising their *DSM* entry as part of a wider, richer life narrative, or rejecting them and finding alternative frameworks to make sense of their experiences. I capitalise upon the fact that Price's turn towards strategic disorganisation and creative incoherence pre-empts the direction that literary studies is taking within the critical medical humanities; it exemplifies the ways in which Woods, Whitehead, Bolaki, and Wasson assert the need to complicate acts of creating and reading narrative, as well as describing the poetics informing contemporary mad studies scholarship. In my own readings of text, I expand Price's methodology to analyse how multimodality, metaphor, entanglement, excess, polyvocality, and hybridity create counter-

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[134] Magi, Jones, Kelly, p. 149, 151.

diagnostic narratives. These are the titular critical strategies through which the authors in this thesis critique their psychiatric diagnoses and resist overly simplistic readings and interpretations of their narratives of mental illness, madness, and distress.

Rationale and synopsis

When I originally started work on this thesis, the first text that I wrote about was Kay Redfield Jamison's *An Unquiet Mind* (1997), one of the most cited and celebrated memoirs of the 1990s memoir boom. Jamison is a leading clinical psychologist on bipolar disorder, as well as living with the condition herself. I analysed how Jamison structured her memoir around the moment of being diagnosed with bipolar and how she negotiates her experiences as a patient with her clinical expertise as a practitioner throughout the narrative. For example, 'as a clinician researcher' Jamison 'strongly believe[s] that scientific and clinical studies […] must be based on the kind of precise language and explicit diagnostic criteria that make up the core of *DSM*-4'[135] However, 'as a person and patient', she 'find[s] the word "bipolar" strangely and powerfully offensive' as it seems 'to obscure and minimize the illness it is supposed to represent', preferring the term manic depression instead.[136] Such tensions arising from the combination of the clinical and personal were what drew me to Jamison's memoir. However, as my research developed, I found myself drawn to less well-known and more experimental, and, in some cases, more contentious memoirs about mental illness. *An Unquiet Mind* is formally straightforward. While Jamison writes graphically about episodes of depersonalisation and violence, her struggles with drug compliance, and her suicide attempt, she does so in a polished, smooth, coherent, and linear manner; her memoir might acknowledge the messiness and disruption of manic depression, but it does so in the neatest way possible. This is appropriate given that Jamison's motivations for writing the memoir were to reassure others

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[135] Kay Redfield Jamison, *An Unquiet Mind* (London: Picador, 1997), p. 181.
[136] Ibid.

experiencing the same symptoms, to educate readers about the diagnosis, and to combat stigma towards mental illness, and I do not want to diminish from any of her aims or achievements. However, I increasingly found that I wanted to work with narratives that engaged with the struggles of how to articulate mental illness, as well as the difficulties of living with it.

As I stated at the beginning of this introduction, writing during the critical turn of the medical humanities fundamentally shaped the motivations and methodologies of this thesis. Rather than using life writing to explore representations of certain mental illnesses in contemporary culture, I wanted my emphasis to be on the multiple ways in which mental illness is narrated in life writing. Rather than privileging texts that provide a 'realist account of a particular medical condition',[137] my selection of memoirs and auto/biographies is based on texts that self-consciously engage with process and form. I take up Whitehead's invitation to look beyond conventional narrative typologies and engage with more experimental, disruptive, hybrid texts;[138] this is not purely out of aesthetic interest, but because these kinds of transgressive narratives, precisely because of their difficulty, have much to say about living with mental illness, madness, and trauma. Additionally, again because of their difficulty, these are texts that have frequently been overlooked by scholarship within autobiography studies and within the first wave of medical humanities work on illness narratives. Similarly, instead of engaging with life writing by celebrated writers who happen to have had experiences of mental illness or madness, which has been the predominant approach taken by literary studies scholars who have ventured into this research area,[139] I wanted this thesis to reflect the diversity of approaches to life writing in contemporary culture: this was never going to be a

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[137] Whitehead and Woods, 'Introduction', p. 4.

[138] Whitehead, 'The Medical Humanities: A Literary Perspective', p. 116.

[139] For example, Stephan Moran analyses writing by William Styron, Ernest Hemingway, and F. Scott Fitzgerald because these writers are 'unusually articulate' about depression: Stephen T. Moran, 'Autopathography and Depression: Describing the Despair beyond Despair', *Journal of Medical Humanities*, 27 (2006), 79-91 (79).

thesis about Sylvia Plath, Virginia Woolf, or even Elizabeth Wurtzel, (or, as it turned out, Jamison).

In Chapter One I use a framework based on feminist psychiatric disability studies to examine three American memoirs about mental illness written by women: Susanna Kaysen's *Girl, Interrupted* (1993), Lauren Slater's *Lying: A Metaphorical Memoir* (2000) and Elissa Washuta's *My Body is a Book of Rules* (2014). *Girl, Interrupted* is the most famous memoir in this thesis, largely due to the 1999 film adaptation starring Winona Ryder and Angelina Jolie. However, unlike the film, the memoir is an innovative and disruptive narrative that unpicks the diagnosis of borderline personality disorder, exposing its inherent gender politics, and calls attention to the power dynamics that shape psychiatric and narrative encounters. Like Kaysen, Slater also examines the arbitrary nature of diagnostic categories in her memoir, *Lying*. She does so by controversially appropriating epilepsy as a metaphor to stand in for her multiple experiences of illness, distress, and sexual abuse, which, she tells us, she has never been able to communicate directly. Both of these memoirists resist fixity and resolution, instead mobilising the ambiguity and uncertainty that accompanies mental illness to challenge the reader to find more nuanced ways of engaging with narratives of distress. The least well-known, but most formally dynamic memoir in this chapter, *My Body is a Book of Rules* is a collection of interlinked essays, each with their own innovative structure, which explore Washuta's entangled experiences of bipolar disorder, disordered eating, surviving rape, and her mixed-race Native American heritage. My analysis of Washuta's memoir is grounded in an intersectional feminist methodology that is attentive to the myriad ways in which these various aspects of her history and identity are interwoven throughout her text. Each of the writers in this chapter are provocative and experimental in their narrative construction, and yet all of them are preoccupied by their perceived lack of credibility. This results in memoirs that self-consciously reflect on issues of doubt, authority, and voice, but nevertheless wilfully refuse to be trapped by generic expectations of life writing.

Disruption continues as a theme in Chapter Two, in which I analyse four memoirs that, to varying degrees, rely on collaboration. Slater's *Welcome to my Country* (1996) is structured as a collection of short stories. Focusing on Slater's role as a clinical psychologist, each story revolves around her relationship with a patient and is used as a springboard from which she can tell her own history of mental illness. *Welcome to my Country* is Slater's first memoir, whereas *Lying*, discussed in the previous chapter, is her third. However, I analyse the texts in this order because of how they speak to the other memoirs in their respective chapters. *Stuart: A Life Backwards* (2005) is an auto/biography by Alexander Masters in which he tells the story of Stuart Shorter and his own relationship with him. Stuart has a complex history of sexual abuse, muscular dystrophy, multiple addiction issues, and a diagnosis of borderline personality disorder, alongside extended periods of homelessness and incarceration. Masters' text self-consciously reflects on the power dynamics involved in telling another person's story of mental illness and trauma, particularly when there is such a gap in privilege between the writer/narrator and the subject of the narrative. I then turn to *Divided Minds* (2005) by monozygotic twins Carolyn Spiro and Pamela Spiro Wagner and *Henry's Demons: Living with Schizophrenia, A Father and Son's Journey out of Madness* (2011) by Patrick and Henry Cockburn, two co-produced familial memoirs. Pamela and Henry both have diagnoses of schizophrenia, while Carolyn and Patrick are neurotypical. Unlike the other two texts in this chapter, these memoirs alternate between writers/narrators and so provide different examples of what it means to jointly tell a story of mental illness. Throughout the chapter I analyse relationality and interdependence across these four memoirs, parsing moments of reciprocity, tension, and conflict in the elusively collaborative telling of one person's mental illness.

I extend my discussion of relationality in the final chapter by turning my focus towards graphic narratives of mental illness and trauma. Comics is a relational form because it depends on the interplay of multiple visual and textual elements on the page for its meaning making. My discussion of comics is also situated as part of the current visual turn within the critical medical humanities.[140] I use Una's *On Sanity: One Day in Two Lives* (2016), a short collaborative memoir told by Una and her mother about the day that her mother was sectioned, to highlight how graphic memoirs make a different kind of intervention in collaboratively narrating mental illness. I then move on to argue that graphic memoirs enforce an engagement with the embodied nature of mental illness because the artist/narrator/subject is drawn as an avatar on the page. Building on this, I turn my discussion towards the *bodymind* – another feminist disability studies concept[141] – that emphasises the inextricability of body and mind in experiences of disability and argue that comics is particularly well placed to extend this concept. This framework is grounded in an analysis of Ellen Forney's *Marbles: Mania, Depression, Michelangelo & Me* (2012), about Forney's life as a bipolar artist, and, finally, the text with which I opened this thesis: Katie Green's *Lighter than My Shadow* (2013), a 508 page long graphic memoir about her entwined experiences of anorexia and sexual violence. Through these texts I also return to some of the themes that are prominent in the prose memoirs in this thesis, namely the memoirist's relationship to their diagnosis, the interrelationship between mental illness and trauma, and challenges to the Recovery Narrative.

Individually and collectively these texts critique the constitutive power of psychiatric diagnoses and trouble typologies of illness narratives. These authors interrupt, disrupt, and erupt attempts to fix the essence of their experiences within circumscribed boxes, be that a narrative template, comics grid, or diagnostic label. Their formal excessiveness also overspills the normative expectations still dominant within life writing and autobiography studies. Yet, while many of the writers listed above revel in their wilful constructions of difference, they also hesitate over the vulnerability that comes with such transgression. Consequently, their narratives are self-conscious and reflexive, as well as adamant. It is striking, given the complex

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[140] Fiona Johnstone, 'Manifesto for a Visual Medical Humanities', *Blog: Medical Humanities*, 31 July 2018 < https://blogs.bmj.com/medical-humanities/2018/07/31/manifesto-for-a-visual-medical-humanities/> [accessed 8 August 2019].

[141] Margaret Price, 'The Bodymind Problem and the Possibilities of Pain', *Hypatia*, 30.1 (2011), 268-84.

ways in which these authors work through their experiences of mental illness, distress, and trauma, coupled with the formal innovation that characterises their texts, that so few of these narratives have received any sustained critical attention. *Girl, Interrupted*, *Lying*, and, to a lesser extent, *Marbles* have been the subject of scholarly investigations of gender and mental illness. However, the other texts are conspicuously absent from critical debates. This is in part, no doubt, due to the ongoing proliferation of illness narratives and the contemporaneity of this thesis, but it also speaks to the continuing need for literary studies to engage with life writing about mental illness.

The originality of this thesis lies not just in its situated readings of texts that have so far been overlooked within critical discussion, but also in its interdisciplinary frameworks and commitment to intersectionality. In my readings of texts, I respond to recent calls within the critical medical humanities to attend to complicated acts of narrative, to interrogate practices of reading illness narratives and to analyse the polyvalent work they perform. Furthermore, my feminist methodology extends current interventions by putting the critical medical humanities in conversation with critical disability studies, critical trauma studies, and autobiography studies to respond to the complex entanglements of mental illness, madness, psychiatric disability, trauma, and distress. In doing so I foreground the interactions and points of connection between mental illness and histories of sexual violence, which have been neglected even in critical medical humanities scholarship. I also analyse the significance of the moment and processes of psychiatric diagnoses, but move beyond this primal scene to consider the aftermaths of such diagnoses, the way they intersect with other determinants of identity, and how they are negotiated and framed in narrative. Throughout the thesis my discussion of these issues and their enmeshments is carried out through analyses of literary form, which celebrate the agency writers claim through experimental and innovative tellings of their lived experiences of mental illness and distress

Chapter 1 Counter-diagnosis and disruption: asserting agency in women's life writing

In 2001 Andrea Nicki called for the establishment of a feminist theory of psychiatric disability.[1] Recognising mental illness as being constituted by both biochemical and social factors, Nicki emphasises the links between trauma – specifically physical and sexual abuse – and mental illness. Her article draws on the social model of physical disability and extends it to encompass psychiatric disabilities; as social structures based on able-bodiedness alienate and disable people with physical impairments, Nicki argues, so do structures based on 'able-mindedness,' isolate and disable those experiencing mental illness.[2] However, Nicki also emphasises that a theorisation of psychiatric disability based on the social model alone is inadequate. Writing back to early feminist work on the relationship between women and mental illness and distress, notably Phyllis Chesler's canonical *Women and Madness* (1972) and Susan Bordo's *Unbearable Weight* (1993), Nicki observes that, although a social constructionist approach to mental illness can shed light on many of the structures that contain and confine women, and their modes of protest against them, there is a danger that this approach may undermine the actuality of mental illness as an illness and/or disability. She writes that 'in order for mental illnesses to be conceived as real illnesses and those afflicted to be treated appropriately, mental illnesses must not be seen purely in terms of their cultural and social components.'[3] Whilst psychological and emotional distress can, of course, be socially produced, social and cultural factors should not obscure, or negate, the experience of mental illness as illness.

In contrast to the plethora of work on gendered disabled bodies, there has been comparatively little work done at the intersections of gender, disability, and mental health. This is in part due, as discussed in the introduction, to disability studies' past reluctance to

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[1] Andrea Nicki, 'The Abused Mind: Feminist Theory, Psychiatric Disability, and Trauma,' *Hypatia*, 16.4 (2001), 80-104.

[2] Ibid., p. 81.

[3] Ibid., p. 83.

engage with medical models, trauma, and pain. Additionally, as Catherine Prendergast has noted, 'disability studies, with its emphasis on the body and not the mind, creates fissures through which attention to the mentally disabled easily falls.'[4] It is striking that despite the exciting critical possibilities that can be seen to be offered by Nicki's call for an engaged feminist psychiatric disability studies, there have (with a few notable exceptions) been few critical interventions paying attention to the interplay of feminisms, psychiatry, disability, and madness. This deficit is both strange and frustrating, and one that I address in this chapter. Contemporary life writing by women that talks about experiences of psychological and emotional distress, both within and outside of medical models, provides a compelling vessel for a discussion of these terms and how they meaningfully play out in the lives of individuals.

In this chapter I analyse three memoirs written by women that negotiate the complexities of their psychological distress and how to write about it: Susanna Kaysen's *Girl, Interrupted* (1993), Lauren Slater's *Lying: A Metaphorical Memoir* (2000), and Elissa Washuta's *My Body is a Book of Rules* (2014). As well as documenting the story of their experiences of mental illness, each of these writers engages with the difficulties surrounding reliability, legitimacy, and authority that inform how the texts are written and received. Each writer also uses multimodal elements and various forms of documentation as tools with which to address the thorny issues of their credibility and authenticity. Consequently, all three refuse to adhere to the simplified redemptive or triumph narrative seemingly required of ill subjects in the neoliberal present.

Kaysen's *Girl, Interrupted* has taken on a cult-classic status. Her memoir reflects on her institutionalisation at McLean hospital in Massachusetts in 1967-68 following a suicide attempt, and her subsequent diagnosis of borderline personality disorder. Made into a film starring Angelina Jolie and Winona Ryder in 1999, the text received, as a consequence, a

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[4] Catherine Prendergast, 'On the Rhetorics of Mental Disability' in *Embodied Rhetorics: Disability in Language and Culture*, ed. by James Wilson and Cynthia Lewecki-Wilson (Carbondale: South Illinois University Press, 2001), pp. 45-60 (p. 46).

second wave of public and critical interest.[5] *Girl, Interrupted* emphasises the gendered nature of the diagnosis of borderline personality disorder and the power dynamics that led to Kaysen's institutionalization. Structured episodically and with photocopies of Kaysen's medical records interspersed throughout, the text reflects on the authority of the psychiatric institution versus that of the individual, additionally calling attention to the credibility of the mentally ill narrator. Slater's *Lying* is similarly challenging and provocative: originally published in the UK under the title *Spasm: A Memoir with Lies*, it engages with the status of truth and authenticity in the telling of Slater's experiences of trauma and mental illness. Sexually abused by her mother when she was a child, but unable to directly engage with this hurt, Slater struggles to find ways to express the impact of the trauma that convey her pain, but do not voice it explicitly. In the same vein as Nicki's call for a more nuanced gendered understanding of mental health, the memoir also confronts the limitations of psychiatry's ability to diagnose and map mental distress effectively. Instead Slater, controversially, turns towards metaphor as a vehicle to narrate the emotions underlying her experiences, often without talking about the events or episodes themselves. Like Kaysen, Slater plays with the role of documentation in her memoir, not by including photocopies of actual documents, but by adapting her writing style and structure to mimic the language and layouts of different kinds of text, which further disrupt her narrative and, again, to call attention to issues of authority. Most recently, Washuta's *My Body is a Book of Rules* traces the author's insecurities over claiming her identity as a mixed race Native American, status as a survivor of rape and sexual assault, disordered eating and bipolar disorder. Washuta uses her memoir in order to witness her sexual assaults and to "work through" (a term that I will unpack later in this chapter) her confusion that surrounds her identity, diagnoses, and trauma. As with the other two texts, Washuta draws upon different formats to structure her experiences, all of which undermine a linear narrative, but here the different modes of documentation produce different emphases:

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[5] *Girl, Interrupted*, dir. by James Mangold (Columbia Pictures, 2000).

while Kaysen and Slater use documents – factual or fictional – to provoke, Washuta mobilizes them as alternative ways of approaching her trauma and coming to terms with her experiences. All three texts provide the nuanced exploration of mental health that Nicki invites in her call for a feminist psychiatric disability studies.

Toward a feminist psychiatric disability studies

As I have begun to indicate, each of these authors is preoccupied by her sense of legitimacy and the unreliability of her narration. This chapter will demonstrate how Kaysen, Slater, and Washuta all pre-empt a doubtful response from their readers; whether this arises from the stigma of having been diagnosed with a mental health condition, or as a result of the structural difficulties that a woman faces when testifying her experiences of sexual violence. Each of these texts is haunted by a fear of not being believed, and each writer pre-empts the disbelief of their readers and directly engages with it, albeit through different means. This self-conscious engagement with the authors' supposed lack of credibility, I will demonstrate, points to wider issues of the gendered nature of authority and power. These women turn to life writing as a platform not only to provide their testimony, but also to debate and deconstruct their (un)reliability. This chapter will illustrate how life writing can return agency to women writing about their experiences of mental and emotional distress and abuse, yet it cannot and does not remove the doubt that they encounter.

Analysing these texts enables me to form a conversation around feminism and mental disability, as well as the intersections of trauma, disability, and mental health discussed in my introduction. This work will build upon the existing scholarship on feminist disability studies and continues the call for attention to be paid to feminist experiences of psychiatric disabilities. Anyone working within, or building upon, feminist disability studies does so through engaging with the heritage of Rosemarie Garland-Thomson. Her works on bodily disabled difference and staring are seminal within the field,[6] but it is her interventions on integrating disability and feminist theory to which I am alluding here.[7] Garland-Thomson illustrates how feminist disability studies could provide more rigorous and nuanced critiques of identity, intersectionality, and embodiment than those previously offered by feminist theory alone. She also recognises the importance of situated theory and the crucial role that life writing has had to play in a feminist disability epistemology.[8] However, her work focuses on narratives and scholarship that refuse pathological and medical models of disability, instead viewing disability as socially constructed. Whilst emphasising that disabilities are not pathologies to be cured is vital in innumerable instances, varying from congenital limb reduction to autism, such an approach becomes difficult in the context of psychiatric disabilities where some will define their experiences as mental illness and actively seek cure, whilst others view their experiences as part of a spectrum of neurodiversity. Part of Garland-Thomson's emphasis on social constructionism and the recognition of the limitations of biomedical models of disability may stem from her work's focus on bodily impairment; feminist disability studies, she states, 'finds disability's significance in interactions between bodies and their social and material environments.'[9] Throughout her writing, Garland-Thomson situates disability in the body, and whilst of course psychiatric disabilities are embodied experiences and should be recognised as such, her disproportionate focus on bodily impairment lacks an appropriate critical language for the analysis of the experience of mental disability.

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[6] See Rosemarie Garland-Thomson, *Extraordinary Bodies: Figuring physical disability in American Culture and Literature* (New York: Columbia University Press, 1997) and *Staring: How We Look* (Oxford: Oxford University Press, 2009).

[7] Rosemarie Garland-Thomson, 'Feminist Disability Studies,' *Signs: Journal of Women in Culture and Society*, 30.2 (2005), 1557-87 and 'Integrating Disability, Transforming Feminist Theory,' in *Feminist Disability Studies*, ed. Kim Q Hall (Indiana: Indiana University Press, 2011), pp. 13-47.

[8] 'Feminist Disability Studies,' p. 1569.

[9] Ibid., p. 1557.

It is within this context that Elizabeth Donaldson called for a move away from social constructionist approaches to mental illness and the social model of disability. In her well-known intervention on the topic, ‘Revisiting the Corpus of the Madwoman: Further Notes Toward a Feminist Disability Studies Theory of Mental Illness,’ Donaldson returns to the figure of Bertha in Charlote Brontë’s *Jane Eyre* – pivotal to feminist critiques of madness due to Sandra Gilbert and Susan Gubar’s seminal 1979 *The Madwoman in the Attic* – to argue for a model of mental illness that is embodied, and consequently viewed in terms of physical impairment.[10] Donaldson asserts that mental illnesses should be interpreted as both medical and physical phenomenon. She argues that feminist disability studies demands attention to be paid to the embodied nature of mental illness in order to move away from interpretations of madness-as-rebellion. Writing about the corporealization of mental illness necessitates more nuanced scholarship on the permeability of the boundaries between impairment and disability because it is harder to maintain the distinction between these terms when talking about mental disorders than it is in the context of physical impairments. I will return explicitly to the interdependency of body and mind, and the embodied nature of mental illness in my discussion of graphic memoirs in Chapter Three using Margaret Price’s concept of the *bodymind*, a term she coins to recognise the enmeshment of the mental and physical in the context of psychiatric disability.[11] Like Nicki, Donaldson writes back to the arguments of Chesler and other anti-psychiatrists, stating that ‘when madness is used as a metaphor for female rebellion, mental illness itself is erased’.[12] Marta Caminero-Santangelo has also voiced this concern, arguing that by focusing on madwomen in literature as subversive figures, protesting against patriarchal social norms, second-wave feminist scholars distanced madness

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[10] Elizabeth Donaldson, ‘Revisiting the Corpus of the Madwoman: Further Notes Toward a Feminist Disability Studies Theory of Mental Illness,’ in *Feminist Disability Studies,* ed. by Kim Q. Hall (Indiana: Indiana University Press, 2011), pp. 91-114.

[11] Margaret Price, ‘The Bodymind Problem and the Possibilities of Pain’, *Hypatia*, 30.1 (2011), 268-84.

[12] Ibid., p. 96.

from its association with mental illness as disease.[13] Like these scholars, this chapter argues that to interpret women's psychological and emotional distress as merely a metaphor for their protest against patriarchal constraints shrinks from the complexity of their lived experience. Nevertheless, whilst madness should not be interpreted as metaphor for rebellion, I demonstrate how women writing about their experiences of mental illness and psychiatric disability can be both rebellious and subversive.

Building on the work of Nicki and Donaldson, Anna Mollow has further problematised the notion of impairment, and complicated the social model of disability, by emphasising the importance of critical sensitivity towards the intersections of race, gender, and mental illness.[14] Through an analysis of Meri Nana-Ama Danquah's *Willow Weep for Me* (1998), Mollow illustrates how Danquah's position as a black female immigrant determines the layered structural inequalities that she faces in accessing health care and in claiming her diagnosis of depression. Mollow's critical attentiveness to the intersections of multiple forms of oppression directly informs my reading of Washuta's *My Body is a Book of Rules.* Washuta is a mixed-race Native American who has a diagnosis of bipolar disorder and has experienced sexual trauma; and each of these interlinked factors contribute to her sense of identity. More recently, Mollow has continued the call for 'a feminism that "will take mental illness seriously": as complex and variable phenomenology, not metaphor or moral failing'.[15] Here she turns towards Feminist Psychiatric Disability Studies and Mad Feminism to enrich feminist theory. She distinguishes these two entities as such:

> If Feminist Psychiatric Disability Studies tends more toward cripistemologies and cultural representations of specific psychiatric disabilities (such as depression, BPD, and autism), Mad Feminism leans more toward subject positions at the margins of

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[13] Marta Caminero-Santangelo *The Madwoman Cannot Speak, Or Why Insanity Is Not Subversive* (London: Cornell University Press, 1998), p. 2.

[14] Anna Mollow, '"When Black Women Start Going on Prozac…": The Politics of Race, Gender, and Emotional Distress in Meri Nana-Ama Danquah's *Willow Weep for Me*,' in *The Disability Studies Reader*, ed. by Lennard J. Davis, 4th edition (London: Routledge, 2013), pp. 411-31.

[15] Anna Mollow, 'Mad Feminism' 24 October 2013 < https://socialtextjournal.org/periscope_article/mad-feminism/> [accessed 18/01/18] (para. 6).

> madness: of those people who might not bear any psychiatric diagnosis label but are nonetheless regarded by the dominant culture as crazy.[16]

I find this a productive distinction, but also take issue with it. Firstly, autism should not be included in the list with depression and borderline personality disorder as it is a developmental learning disability; whilst it can be referred to as a 'mental disability,' it is not psychiatric. Secondly, what I find deceptive about this definition is that it makes it appear as though each of these separate fields is well established and backed up by substantial bodies of work, whereas my research has shown that this is simply not the case; even though I wish it were so. There are individual instances of scholarship that can be classified under the umbrella of a feminist psychiatric disability studies - Nicki, Donaldson, Mollow, Price, and Prendergast - yet these instances are still at the margins, and there is negligible work to be found that identifies as mad/neurodiverse/feminist.

In this chapter I apply a feminist psychiatric disability studies approach to contemporary life writing about mental illness. I bring together feminism, psychiatric disability, trauma, and memoir through the focus of reliability and authority because women, people with experiences of mental illness, survivors of sexual violence, and memoirists all routinely experience doubtful responses to their self-narratives. It is unsurprising then that when a woman who has a diagnosis, or multiple diagnoses, of mental illness, writes a memoir, she does so with a heightened awareness of her credibility, and the potential attacks on it that will follow her text's publication. To understand the power of these contexts, I will also explore some of the doubting responses made by critics to such work and chart the ways in which this further reflects on the role of the critic as diagnostician and witness.

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[16] Ibid.

Women's life writing and credibility

Interrogating issues of credibility, legitimacy, and authority is nothing new in the context of life writing by women. Discussions about the relationship between gender and truth have been present since women's autobiography first became a source of study.[17] Leigh Gilmore in particular has a long-standing critical interest in authority, truth, self, and gender. Her early work started to explore the ways in which autobiography engages with discourses of truth and identity, and how feminist practices of self-narration drew upon 'interruptions and eruptions, with resistance and contradiction as strategies of self-representation.'[18] Following *The Limits of Autobiography: Trauma and Testimony*, discussed in the introduction, Gilmore's work continued to pursue the vulnerabilities and instabilities that underlie self-narratives. In the wake of the memoir boom/lash,[19] Gilmore investigated memoirs that had caused controversy due to allegations of falsehood. Rather than simply discrediting fakes, she illustrates how they highlight the fundamental issues at stake in the genre of autobiography.[20] Productively demonstrating how scanning memoirs for their inaccuracies and discrediting them accordingly reduces what they can teach us about the life-writing genre and identity politics, Gilmore suggests replacing the labels of 'nonfiction' and 'fiction' with the 'literary' and 'testimonial' as categories by which to assess fake memoirs. By thinking through the insecurities that such memoirs provoke, rather than attending to squabbles of facts versus lies, she maintains, we would then learn 'about vulnerabilities at the heart of memoir,' and identity politics more

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[17] See Sidonie Smith, *A Poetics of Women's Autobiography: Marginality and the Fictions of Self-Representation* (Bloomington: Indiana University Press, 1987); Sidonie Smith, 'Constructing Truths in Lying Mouths: Truthtelling in Women's Autobiography,' *Studies in the Literary Imagination,* 23.2 (1990), 146-63; Sidonie Smith and Julia Watson (eds), *Women, Autobiography, Theory: A Reader* (Madison: University of Wisconsin Press, 1998).

[18] Leigh Gilmore, *Autobiographics: A Feminist Theory of Women's Self-Representation* (London: Cornell University Press, 1994).

[19] See Leigh Gilmore, 'Boom| Lash: Fact-Checking, Suicide, and the Lifespan of a Genre', *a/b: Auto/Biography Studies,* 29 (2014), 211-24.

[20] Leigh Gilmore, 'Learning from Fakes: Memoir, Confessional Ethics, and the Limits of Genre,' in *Contemporary Trauma Narratives: Liminality and the Ethics of Form,* ed. by Susana Onega and Jean-Michel Ganteau (London: Routledge, 2014), pp. 21-35.

widely.[21] Thinking through the terms of the literary and the testimonial, Gilmore illustrates, 'generate[s] complex and mingled reading practices;' ones that 'engage with our own credulity,' and encourage engagement 'with the literary capacities of the form.'[22] Gilmore's principal argument here is that fakes, and the controversies that they provoke, throw a spotlight on pre-existing judgements that enshroud, and normative values that underpin, uses of the autobiographical "I."

In her most recent monograph, *Tainted Witness,* Gilmore analyses women's testimonies of sexual violence in both legal and literary contexts, as well as the judgements against them.[23] She demonstrates how women who testify of their sexual abuse are doubted and discredited, and can do little to counteract the deep-rooted bias against their gender, authority, and notions of permissible violence. Beginning with the 1991 case between Anita Hill and Clarence Thomas, Gilmore establishes how Hill's testimony was systematically undermined and her status as witness tainted, and argues that this marked a new phase in discrediting women's public accounts of sexual misconduct.[24] Analysing legal cases, memoirs, autobiographical fiction, humanitarian campaigns, and online protest movements, Gilmore traces testimonial networks and their search for adequate witness.[25]

In her chapter on memoirs and testimony, Gilmore thinks through Kathryn Harrison's notorious narrative of incest *The Kiss* (1997); expands on her work on James Frey's *A Million*

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[21] Ibid., p. 23.

[22] Ibid.

[23] Leigh Gilmore, *Tainted Witness: Why We Doubt What Women Say About Their Lives* (New York: Columbia University Press, 2017).

[24] Hill publicly testified that Thomas, U.S. Supreme Court nominee, had repeatedly sexually harassed her in the workplace. This case has resurfaced in public debate as a benchmark in the recent Brett Kavanaugh hearing, in which Dr Christine Blasey Ford testified that he sexually assaulted her. The frequency and ferocity with which women's accounts of their sexual violence are doubted became part of public discourse when Tarana Burke's Me Too campaign became a hashtag in the aftermath of the Harvey Weinstein sexual abuse allegations.

[25] Gilmore defines testimonial networks as 'circulatory systems that connect the discourses and sites through and across which persons and testimony flow' (p. 3). An adequate witness is 'one who will receive testimony without deforming it by doubt, and without substituting different terms of value for the ones offered by the witness herself' (p 5).

Little Pieces (2003) by exploring Oprah Winfrey’s role as a witness; and considers the transition from testimony to self-help literature enacted by Elizabeth Gilbert’s *Eat, Pray, Love* (2006), and Cheryl Strayed’s *Wild* (2012). The greatest strength of this chapter is its situation of self-narratives in the contemporary neoliberal context. Gilmore illustrates how neoliberalism is responsible for the dominance of the redemption, or overcoming narrative. Neoliberalism diverts attention away from structural problems by placing responsibility for their resolution with the individual and their capacity to strive for self-improvement. This is obviously extremely problematic for people with disabilities and chronic illnesses. Neoliberalism exacerbates the popularity of triumph and quest narratives in which the period of illness or impairment is viewed as an interruption to an otherwise linear, coherent, and heteronormatively fulfilling life narrative. Gilmore argues that memoirs in the 1970s and 80s, such as Monique Wittig’s *Lesbian Body* (1975) and Carolyn Steedman’s *Landscape for a Good Woman* (1986), were challenging and provocative in the ways that they resisted narrative resolution, invested in multiple feminist “I”s, and highlighted histories of violence and connected them to contemporary episodes of trauma. However, in the wake of memoir’s boom/lash and the growth of neoliberalism, redemption narratives became not only normative, but the norm and this resulted in a lack of tolerance for other life narratives that do not fit their neat template. Consequently, Gilmore asserts that memoir’s political potential was ‘absorbed within neoliberalism’ and that the form was emptied of its challenging content and aesthetic innovation.[26]

Whilst such absorption may indeed have been the overarching trend from the 90s to the present day, this chapter focuses on exceptions to this rule. In the context established by Gilmore, Washuta’s *My Body is a Book of Rules* becomes even more extraordinary. Rather than having been emptied of meaning and provocation, Washuta’s memoir actually is the most aesthetically challenging of the three texts in this chapter. The fact that it is so reminiscent of

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[26] *Tainted Witness*, p. 94.

Girl, Interrupted and *Lying* despite the increased neoliberal pressures exerted on memoirists to conform and produce stories of individualist triumph is remarkable. Indeed, it is striking that each of these texts, published at different moments of the memoir boom/lash, and at different moments in feminist movements, are so resonant with one other. The fact that they speak to each other so pertinently is not merely because of parallels that can be traced across the authors' experiences of psychological and emotional distress, or even simply because each writer is preoccupied with asserting her authority in the face of doubt; rather commonalities are created through the challenge that each memoir presents its reader. There is something inherently rebellious in how Kaysen, Slater, and Washuta frame their stories. As well as befitting the complexity of each writer's experiences, the formal innovation that underpins all of these memoirs enacts a wilful refusal to adhere to a neat, simplified, and reductive account of mental illness.[27] And whilst we need to discontinue the trend of feminist literary criticism treating madness as metaphor for a woman's rebellion, there is space for a feminist literary criticism that is engaged with psychiatric disability studies, to celebrate the rebelliousness with which female writers like Kaysen, Slater, and Washuta are disruptive, wilful, and obstinate in how they write their experiences of mental illness and abuse.

Girl, Interrupted and *Lying: A Metaphorical Memoir*

Girl, Interrupted and *Lying* have become seminal narratives of mental illness. Kaysen's popular memoir is a touchstone for academics writing on mental health, gender, and life writing. Despite this, there is little in-depth critical work on the memoir; rather it tends to be referred to in passing as a way of initiating a discussion of how these issues interact in a different set of texts. Writing on *Girl, Interrupted* now runs the risks of being seen to be unoriginal, and yet there is much left to be said about the complexities of the text, particularly in what it offers a

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[27] Reading Sara Ahmed has recently reminded me that wilfulness, disobedience, disruption, and obstinacy are entwined with feminism. See Sara Ahmed, *Living a Feminist Life* (London: Duke University Press, 2017).

thinking through of feminist psychiatric disability and how it interacts with other subversive accounts of mental illness written by women. In contrast, *Lying* was a less popular memoir, but has received a glut of critical attention. Slater is a trained clinical psychologist who has also been repeatedly institutionalized and diagnosed variously with major depression, bipolar disorder, anorexia, borderline personality disorder, and obsessive compulsive tendencies. However, rather than a catalogue of Slater's medical history, her third memoir, *Lying*, is both a personal reflection on how best to communicate the experience of mental illness and a challenge to the expectations seemingly inherent in the structure and telling of illness narratives and autobiography.

My analysis of these memoirs argues that their respective struggles with diagnosis produces a textual self-consciousness that engages with the writers' sense of reliability, credibility, and authority.[28] This worrying over diagnosis, its applicability, and nuance, or lack thereof, and the links made to female experiences of mental health and trauma, and a woman's authority in the telling of these experiences is precisely the kind of work that belongs at the heart of a feminist psychiatric disability studies. In their subversive unpacking of diagnosis and questioning of authority, Kaysen and Slater draw upon numerous postmodern techniques of narrative structuring and multiple kinds of document and text, and in doing so they undermine the common expectations of the illness narrative and crucially, deconstruct diagnosis, both as a medical narrative-cum-label, and as a mode of reading that fails to pay attention to the complexities and nuance of life writing about mental illness.

Girl, Interrupted is an inherently counter-diagnostic text. Whilst part of Kaysen's motivation for writing was to challenge her diagnosis of borderline personality disorder and subsequent institutionalisation at McLean, the text is not, as it is often read, a simple "writing

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[28] Such a complication and rejection of diagnosis surpasses the arguably more recognisable anti-psychiatry narratives of memoirs such as Kate Millett's *The Loony-Bin Trip* (1990), in which she recollects and protests her forced hospitalization for manic depression, as here the mode of resistance permeates the very form of the text.

back" narrative. Throughout *Girl, Interrupted* Kaysen literally juxtaposes medical authority with her own account of her time at McLean by interspersing photocopies of her psychiatric files between her vignettes. These two different types of life writing – one medical, written about her at the time of her diagnosis – and the other, her subjective account written retrospectively – frequently contradict each other. Timothy Dow Adams argues that Kaysen's motivation for including these documents is twofold: firstly she uses them to argue that she was misdiagnosed, and secondly to illustrate the inadequacies of the documentation system 'of the mental health world.'[29] Whilst Adams' article provides a rigorous close analysis of the photocopies and the information contained within them, his argument that Kaysen 'wants to reproduce the documents with as much accuracy as possible for the purpose of demonstrating that she was not treated fairly' lacks sophistication.[30] True, some of the documents draw attention to inadequacies within the mental health system; however, I argue that their inclusion is part of Kaysen's wider reflection on the impact of her diagnosis and institutionalisation upon her perceived credibility. In one vignette Kaysen directly asks her reader 'Do you believe him [the doctor] or me?' and presents two alternative histories detailing the event of her referral. The doctor who referred her states that he interviewed Kaysen for three hours before making his decision; Kaysen claims that he took only twenty minutes. Using evidence taken from the photocopies of her admission notes, Kaysen constructs two different versions of events to back up each claim, pointedly stating that both cannot be true, that rather the reader must choose who they believe, and then accept the implications of that choice. Here Kaysen simultaneously undermines medical authority and draws attention to the unreliability inherent to her own narration. This episode acts an example of a wider battle surrounding authority between individual and psychiatric institution throughout the memoir. In staging the two, mutually exclusive, equally conceivable options,

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[29] Timothy Dow Adams, 'Borderline Personality: Autobiography and Documentary in Susanna Kaysen's *Girl, Interrupted*,' *Life Writing* 2.2 (2005), 119-37 (128).

[30] Ibid,. p. 129.

Kaysen confronts the reader and forces them to acknowledge her unreliability, and their reaction to it.

This choice between the doctor's and Kaysen's accounts is implicitly gendered and, within such a frame, stages a battle for authority between institution and patient. In a vignette entitled 'The Taxi' Kaysen narrates the scene of her referral and depicts the doctor as authoritarian, paternalistic, and self-assured. He states 'You have a pimple,' to which Kaysen nods; he continues 'You've been picking it,' and concludes: 'You've been picking at yourself;' to which Kaysen also nods because 'He was going to keep talking about it until I agreed with him, so I nodded' (p. 7). The encounter continues with the doctor assuming knowledge about Kaysen's life without her input: he asks questions, but nods before she starts to answer. Repeating his statement 'Picking at yourself,' the doctor proclaims: 'You need a rest' (p. 7). In another aside Kaysen reflects that she probably did need a rest, having got up early and taken multiple trains to see the doctor before work. Consequently, in response to the doctor's repeated leading questions 'Don't you think? […] Don't you think you need a rest?' Kaysen, speaking for the first time, replies 'Yes' (p. 8). The way in which Kaysen juxtaposes her narrative asides and the doctor's speech – mirroring the juxtaposition of photocopy and narrative throughout the memoir – enacts the gulf between the two parties and belittles the doctor's authority. Within this mode of telling, it is ridiculous, comic, and tragic that in a paragraph the doctor is presented as having made the leap from noting a burst pimple to inferring self-harm and deciding that Kaysen needed to be institutionalized. This is exacerbated by the caricature-esque descriptions of the doctor, who announces, strides, and struts, is pleased with himself, and even triumphant (pp. 7-8). He is overwhelming and threatening, sounding 'conciliatory, or pleading' (p.8), 'lung[ing] towards' Kaysen, 'b[earing] down on [her] with his belly,' and 'pinch[ing her] between his large stout fingers' (p. 8). Physically overbearing, the doctor forces Kaysen into a taxi, 'slam[s]' the door and, lifting an arm to point at her, as if bestowing a sentence, declares 'Take her to McLean […] and don't let her out till you get there' (p. 9). The gender politics of this encounter are blatant. The conceited, aloof, and domineering older male forces the tired, silent, reluctantly acquiescing young woman to be institutionalised. This satirical, though nevertheless disturbing, stereotyped presentation of the doctor places Kaysen as helpless against medical authority.

It is easy to be taken in by Kaysen's persuasive narratorial voice, and either forget that she had been institutionalised on the grounds of a suicide attempt, or, alternatively, to side with Kaysen against the doctor who institutionalised her and (particularly through a gendered reading of the event) disbelieve the veracity of her diagnosis. This is even more tempting upon encountering Kaysen's charm and wit; for example, she moans how she and the other members of her ward 'traipsed off day after day to exhume the past' (p. 87), describes the doctors as 'hors d'oeuvres' and the therapist as 'the entrée' (p. 87), and comically undermines the privacy violation of having to have a 'shaving supervisor' by calling the hairy-legged girls 'early feminists' (p. 57). However, the choice – to believe the doctor or Kaysen – is further complicated when Kaysen narrates an episode of depersonalisation in which she suddenly and urgently had to prove that she had bones in her hand. Worried that she did not, Kaysen bites herself 'to see if [she] crunched down on something hard' (p. 102); she then began scratching the back of her hand with the intention of 'get[ting] hold of a flap of skin and peel[ing] it away, just to have a look' (p. 102). Becoming desperate in her attempts to find her bones, Kaysen draws blood and continuously asks 'Do I have any bones? Do you think I have any bones?' until a nurse sedates her. This narrated account is followed by a photocopy of a progress note that also details the episode, stating that the depersonalisation lasted 'for about six hours at which time she felt that she wasn't a real person, nothing but skin. […] She mentioned that she would like to see an X-ray of herself to see if she has any bones or anything inside' (p. 105). This episode provides a stark contrast with the controlled, cynical narrative voice to which the reader has become accustomed; its account of a suddenly vulnerable embodiment sits at odds with the narrative control the text has practised so far. This particular 'interruption' is, of course, another part of that control, but it constitutes Kaysen's willingness to recount an episode when comprehension was obscured and redefined by the actuality of mental illness, and when the re-articulation in memoir mode does not lay claim to any clear retrospective authority.

These apparent inconsistencies and fluctuations make categorising Kaysen difficult; and she shares the reader's confusion around the state of her mental health. Kaysen's retrospective narration is frequently unable to clarify or decide upon the extent of her mental illness: early in the memoir she states, 'I knew I wasn't mad' (p. 42), but later, just after the episode of depersonalisation discussed above, she writes: 'now I was really crazy, and nobody could take me out of there' (p. 104), yet even later she reflects: 'maybe I was just flirting with madness […] I wasn't convinced I was crazy, though I feared I was' (pp. 158-59), and then immediately follows this by saying that she often still asks herself whether she is 'crazy' (p. 159). The resulting destabilising impact produces multiple consequences: the use of discrepancy, contradiction, and antagonism create fissures in the textual fabric; and it also problematises the text's reception, through the questions inevitably raised about Kaysen's reliability as a narrator – as she acknowledges in the text, having been diagnosed and institutionalised, there is 'one thing [that she] would always lack: credibility' (p. 93). The challenge as to where the reader can locate her/himself in relation to the text's aesthetics creates unease, rather than the revelation and explication that might be expected. Part of this confusion stems from the arbitrariness and superficiality of a binary model of sanity and madness, but it is also due to the fraught relationship that Kaysen has with her specific diagnosis.

Towards the end of her memoir, Kaysen literally deconstructs her diagnosis of borderline personality disorder by copying out its entry from the 3rd edition (1987) of the *Diagnostic and Statistical Manual of Mental Disorders*. As I stated in the introduction, the *DSM* has been frequently criticised for its standardised diagnoses, symptom-based approach, neglect of psychosocial factors, and pathologisation of everyday behaviour, and in the vignette following the *DSM* text Kaysen provides what she calls 'an annotated diagnosis' (p. 150) in which she reflects on the applicability of these diagnostic criteria to her previous self.[31] The *DSM* entry is, she states, 'accurate but it isn't profound. It's not even a case study. It's a set of guidelines, a generalization' (p. 150). At many points Kaysen comically undercuts the authority of the diagnosis, citing its focus on 'instability of self-image, interpersonal relationships and mood […] uncertainty about […] long term goals or career choice.' 'Isn't this a good description' she asks knowingly, 'of adolescence?' (p. 151). She criticises the gendered nature of her diagnosis that accuses her of 'compulsive promiscuity' (p. 157), questioning how many women a man would have to have sex with in order to earn this label, and unpicks the impact of 1960s societal expectations defining what was considered a symptom, rather than merely a personality trait or lifestyle choice. However, she is also surprised by the applicability of the diagnosis and recognises herself in the list of features, for example 'wrist-scratching! I thought I'd invented it' (p. 152). As a consequence of this second set of readings, Kaysen wonders 'perhaps I'd actually had an identity disorder' (p. 154). This continuous ambiguity and uncertainty of Kaysen's mental health at the time of her institutionalisation, and the consequent applicability, or not, of her diagnosis is central to *Girl, Interrupted.*

Feminist psychiatric disability studies provides the tools to handle the complexities of Kaysen's fraught relationship with her diagnosis. It does not require the reader to decide whether Kaysen was either well and violated by psychiatry, or ill and an (especially) unreliable narrator. Indeed, to categorise her either way is a diagnostic, and overly simplistic, move; instead her narrated self exists somewhere between and across these options. A reading of *Girl, Interrupted* informed by a feminist theory of psychiatric disability engages with the

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[31] Borderline personality disorder is still a contentious diagnosis today. It is particularly notorious for discrediting patients and increasing the likelihood of them receiving discriminatory treatment. See Jay Watts, 'Testimonial Injustice and Borderline Personality Disorder,' *The Huffington Post*, 14 February 2017 < https://www.huffingtonpost.co.uk/dr-jay-watts/testimonial-injustice-and_b_14738494.html> [accessed 24 April 2018] and Jay Watts, 'Borderline Personality Disorder – A Diagnosis of Invalidation,' *The Huffington Post*, 27 September 2017 < https://www.huffingtonpost.co.uk/dr-jay-watts/borderline-personality-di_b_12167212.html> [accessed 24 April 2018]. It has also been argued that BPD pathologises women's distress resulting from sexual trauma: see Clare Shaw and Gillian Proctor, 'Women at the Margins: A Critique of the Diagnosis of Borderline Personality Disorder,' *Feminism & Psychology*, 15.4 (2005), 483-90.

contradictions presented by Kaysen; aware of the gender politics, it is sympathetic to her antagonism towards the medical practitioner who committed her and the institution that detained her, not daunted by the contradictory narrations of events, and is prepared to believe her. It is also critical of the socially prescribed limitations of the diagnosis of borderline personality disorder, and acknowledges the impact of the historical / cultural context in determining what is considered a symptom, and who is considered deviant. However, such a reading is also wary of, as Nicki put it, seeing mental illnesses 'purely in terms of their cultural and social components.'[32] As such, it acknowledges the importance of the inclusion of episodes such as Kaysen's depersonalisation because of how they complicate the memoir beyond a simple "writing back" narrative. With Donaldson's insight that 'when madness is used as a metaphor for female rebellion, mental illness itself is erased'[33] in mind, I have demonstrated the difficulty posed by *Girl, Interrupted*, simultaneously acknowledging the gendered power dynamics that Kaysen resists, yet also recognising that a disproportionate focus on Kaysen's non-conformism distracts from the actuality of her mental illness.

With its episodic structure and interspersed photocopies, *Girl, Interrupted* is a memoir that insistently interrupts itself. However, the title comes from Vermeer's painting 'Girl Interrupted at her Music,' which Kaysen narrates viewing on two separate occasions in the final vignette of the memoir. Vermeer's painting depicts a young girl looking up from her music and staring out directly at the viewer. Behind her, and enclosing her, is an overbearing male music teacher with one hand on the girl's music, and the other on the back of her chair; I cannot help but be reminded of Kaysen's description of the doctor's 'large stout fingers' (p. 8) from the vignette in which she is referred to McLean. Sombrely lit, the painting is muted, with the exception of the girl's face, which is bright. Prior to her institutionalisation and diagnosis, Kaysen had seen the painting at the Frick Collection in New York, accompanied by her English

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[32] Nicki p. 83.

[33] Donaldson, 2011 p.96

teacher, who would later kiss her. On that occasion, stumbling upon the painting, Kaysen recoils, interpreting the girl as warning her of something, as if 'she had just drawn a breath in order to say […] "Don't!"' (p. 166). Unwilling to heed this warning, Kaysen turns away from the painting, unable to face the girl's 'urgency'. Re-visiting the museum sixteen years later, post-institutionalisation, Kaysen finds the painting again. From her position of distance writing in the 1990s, Kaysen tells us she now reads the girl as sad rather than urgent, looking out for someone to recognise her. This time, Kaysen not only recognises the girl, but recognises herself in the girl / as the girl:

> Interrupted at her music: as my life had been, interrupted in the music of being seventeen, as her life had been, snatched and fixed on canvas: one moment made to stand still for all the other moments, whatever they would be or might have been. What life can recover from that? (p. 167).

Instead of turning away as before, on this occasion Kaysen tells the girl 'I see you' (p. 167). The language Kaysen uses to describe the painting is counter-diagnostic; the snatching and the fixing depict Kaysen's anger at the way that one moment is made permanent and representative, and traps the girl (and by proxy herself) in a stasis from which she can neither escape, nor recover. There is a distinct irony in the fact that, coming at the end of the memoir, it is a *visual* artwork that Kaysen feels best depicts her feelings towards her period of institutionalization and the impact that it had on her identity. It is through the light of the painting, 'the fitful, overcast light of life' by which Kaysen comes to see herself, even if only 'imperfectly'(p. 168).

Even more so than Kaysen, Slater is critical of the arbitrary nature of diagnosis. In the afterword to *Lying*, Slater argues that 'diagnosis itself is a narrative phenomenon,' rather than any source of objective truth (p. 222). She is caught between multiple diagnostic categories which, she demonstrates, 'come in and out of vogue as fast as yearly fashions' (p. 222):

> the same symptoms doctors saw as epilepsy in one era of my life, they saw as borderline personality disorder in another era of my life, and then as posttraumatic

> stress disorder in yet another era, and as bipolar, and as Munchausen's, and as obsessive-compulsive disorder, and as depression, and even once, as autism. (p. 222)

This is not the only time that Slater has expressed her criticisms of the diagnostic process. Her non-fiction book, *Opening Skinner's Box: Great Psychological Experiments of the Twentieth Century* (2004), included a chapter entitled 'On Being Sane in Insane Places,' in which she recreated David Rosenhan's famous 1973 anti-psychiatry experiment by presenting at multiple emergency rooms stating that she could hear the word 'thud,' and recording the number of anti-depressants and anti-psychotics that she was prescribed, in order to undermine the diagnostic process and draw attention to contemporary psychiatry's reliance upon pharmaceutical solutions.[34] Lacking a satisfactory diagnostic, explanatory label with which to neatly convey and explain her experiences, and arguing that 'there is no truth' in diagnosis, Slater rejects it, both as narrative structure and as signifier of identity. Instead, in *Lying*, she opts for an alternative metaphorical mode of discourse, based not on a reading of symptoms but rather on the messy possibilities – in terms of both psychology and textual form – of subjective and emotional truth.

Ostensibly, *Lying* narrates the lived experience of epilepsy, coupled with a coming-of-age narrative that explores Slater's fraught relationship with her mother, who, it is hinted, abused her as a child, and her developing sexuality. However, the memoir is not so straightforward. Whilst Slater claims to take anticonvulsant medication daily, the chief use of epilepsy in the memoir is to act as an extended metaphor by which to convey Slater's composite mental illnesses and childhood trauma of sexual abuse. Her experiences of sexual abuse remain beneath the surface of the narrative, and are alluded to but never directly explored; this is in contrast to her first memoir, *Welcome to my Country*, discussed in the next

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[34] For in depth analyses of Slater's experiment and the damning responses by psychiatrists to it, see Elizabeth J. Donaldson, 'Lauren Slater's Lying: Metaphorical Memoir and Pathological Pathography', *Gender Forum,* 26 (2009), n.p, <http://www.genderforum.org/print/issues/literature-and-medicine-ii/lauren-slaters-lying/?fontsize=2> [accessed 24 June 2015] and Lindsey Grubbs, 'Lauren Slater and the Experts: Malingering, Masquerade, and the Disciplinary Control of Diagnosis,' *Literature and Medicine*, 33.1 (2015), 23-51.

chapter, in which her history of sexual violence is unpacked somewhat more explicitly. Whether or not Slater is actually epileptic is purposefully never revealed, and to definitively label her as epileptic or not defeats the object of the text; either way *Lying* cannot (and by implication should not) be read as a cultural representation of the condition. This is not its purpose, and Slater deliberately tells her reader that if the memoir is read literally, as 'just one more true account of yet another disease,' she has 'failed' (p. 162).

In addition to having, or not having, epilepsy, half way through the memoir Slater introduces a potential, but, again unconfirmed, diagnosis of Munchausen's syndrome. Munchausen's status as a factitious illness in which patients feign symptoms in order to gain attention and treatment is a perfect choice for *Lying*'s meditation on the politics of reliability, credibility, and legitimacy, and the potential of indirect revelation in the illness memoir. 'Munchausen's is a fascinating psychiatric disorder,' Slater writes, because 'its sufferers [are] makers of myths that are still somehow true, the illness [is] a conduit for real pain' (p. 85). The ways in which patients with Munchausen's disorder perform symptoms of other illnesses signify deeper psychic distress that they cannot engage with directly. Consequently, it provides the perfect vehicle for Slater to dismantle expectations of illness narratives and problematise the diagnostic process, as well as to write about her experiences of trauma without directly voicing them. 'So that [we] will understand Munchausen's better,' Slater includes quotes from *The British Journal of Psychiatry*, *The Journal of Existential Psychiatry*, and *The Annals of Psychiatry*. These are, however, fictional excerpts from journals that, in some cases, exist, but the rest of Slater's provided citations are false, or were discontinued a long time ago, or do not exist but have a name similar to a journal in current circulation. It is fitting that a discussion of Munchausen's disorder is backed up with false evidence from sources that initially appear convincing, yet do not withstand closer inspection; Slater's inclusion of these crafted excerpts enacts the tendency of the patients with Munchausen's to research and become "experts" on the illness that they simulate. To give one example, the factitious excerpt that claims to be from '*The Annals of Psychiatry*, volume 98, pp. 38-44' relates the case of an adolescent girl called, for the purpose of the study, Jean Levy. Whilst there was ‘absolutely no physiological evidence of any epileptic activity,’ the girl convinced people that she had temporal lobe seizures ‘to the point where she wrote and published an account of her illness, and yet on the other hand, she prominently placed a book entitled *Patient or Pretender* on the shelf in her hospital room’ (p. 90). It is impossible not to notice, and not to smile at, the similarities between this patient and Slater (particularly given that Slater later pretends that her middle name is Jean at a writers’ conference). The excerpt provides Slater with a way of indirectly commentating on herself – she assumes another kind of authority, here a psychiatric journal, and writes a case that parallels her own so closely that the discussion cannot but be transferred to her memoir. As we will see, this is not the only instance in which Slater assumes another identity in order to provide commentary on her experiences and their construction in narrative.

Lying literally, then, presents the reader with four possible options as to the state of Slater’s health (pp. 160-61): it is technically possible, though appears extremely unlikely, that Slater has epilepsy and that *Lying* is as accurate an account as she is able to write; potentially she has epilepsy, but much of her written experiences are exaggerated; contrastingly, she may not have epilepsy, but may have Munchausen’s syndrome, and thus her feigning of epilepsy is a true account of someone who is pathologically inclined to lying; or, most convincingly, she has neither epilepsy nor Munchausen’s, but metaphor and indirection are the only ways in which she can narrate the ‘subtleties and horrors and gaps’ in her past for which she cannot find the words (p. 220). Refusing to confess which option is accurate, the text weaves its way between the factual, hyperbolic, metaphorical, and fictional, purposefully disrupting the diagnostic urge in the creation of a reading experience which is vertiginous, disorientating, and, as Slater herself terms it, ‘exasperating’ (p. 223).

Clearly *Lying* is a text in which Slater is preoccupied with issues of reliability and legitimacy. As made clear from its title, the memoir immediately takes a stance against the expectations of honesty, truth, and transparency attached to the memoir genre, and –

concomitantly – the credibility of Slater as the narrator/writer. In case the title is not sufficient warning that truth in this memoir is 'bendable' (p. 5), chapter 1 is a vignette of two words: 'I exaggerate' (p. 3). From the outset, then, Slater alerts her reader to the unreliability of her narration, and this transparency about her tendencies towards the hyperbolic and fictive continues throughout the text as she repeatedly warns her reader that she is 'not to be trusted' (p. 144), and that she 'often disregard[s]' the facts (p. 144). If Kaysen suggests the variability of event and its recollection through process of textual juxtaposition and cutting, Slater addresses it directly in comments that stress that the lack of authoritative commentary is a given. Slater's incessant self-conscious signalling of her unreliability demonstrate her 'insecurity and guilt' in blurring the boundaries between historical and narrative truth, whilst also insisting that it is the most appropriate means by which to tell her tale.[35] In an interview with Alys Culhane, Slater distinguishes between an 'unreliable writer' and an 'unreliable narrator' by saying that the latter warns you of their unreliability, and so 'the terms of the contract are spelled out clearly from the very beginning.'[36] Slater's use of 'contract' is particularly appropriate considered in light of Philippe Lejeune's theorisation of the autobiographical pact, referenced in the introduction to this thesis. Also crucial to such an ethics of autobiography is Eakin's body of criticism which, as I mentioned in the introduction, locates telling the truth as the primary rule of autobiographical discourse.[37] Furthermore, because autobiography is performative, as Eakin emphasises, telling the truth is both a requirement of genre and identity; judgements against an autobiographical text that lies become so emotionally charged, less because people are particularly upset with contravening the rules of a literary genre, but because of a perceived moral imperative to tell the truth.

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[35] Alys Culhane and Lauren Slater, 'Interview with Lauren Slater', *Fourth Genre: Explorations in Nonfiction,* 7 (2005), 157-72 (pp. 169-70).

[36] Culhane (pp. 169-70).

[37] Paul John Eakin, 'Breaking the Rules: The Consequences of Self-Narration,' *Biography,* 24.1 (2001), 115-27.

As we have started to realise from Slater's deployment of fictional excerpts from journal articles, lying permeates the form of the memoir, as well as dictating its content. Epilepsy provides not only the central metaphor, but also the framework of the text. *Lying* is structured as a tonic chlonic: part one is called 'onset,' part two 'the rigid stage,' part three 'the convulsive stage,' and part four 'the stage of recovery.' However, the linear overcoming trajectory this implies is deceptive given that the text repeatedly shifts and interrupts itself with flashbacks and numerous multimodal elements. Like Kaysen, Slater draws upon different kinds of document in order to question authority and reflect on her credibility. Whilst the documents in *Girl, Interrupted* were real photocopies of Kaysen's medical records, Slater plays with the form of her memoir by creating fictional documents including, in addition to the excerpts from psychiatric journals, a meta-introduction, a letter to the reader, a journal article entitled 'The Biopsychosocial Consequences of a Corpus Callostomy in the Pediatric Patient,' supposedly by Carlos Neu, M.D and Patricia Robinson, P.T. and a memo to her publisher at Random House, 'How to Market this Book.' The introduction to *Lying*, purportedly written by Hayward Kreiger, a Professor of Philosophy at the University of Southern California, provides a recommendation for how to read Slater's memoir. Describing the memoir as 'disturbing' and 'unsettling,' Krieger warns the reader of Slater's 'incrementally rising refusal to state the facts of the illness about which she writes' (ix), and introduces them to the idea that epilepsy may be 'a meaningful metaphor' to communicate the 'unutterable experiences in her life' (ix). He asks that the reader approach the text with 'an open and flexible mind,' so that they might benefit from 'the truth of the liminal, the not-knowing, the truth of confusion,' which, he asserts, can offer more than a straightforward confessional illness narrative (x). This introduction is, in fact, written by Slater, and the fact that she takes on an academic persona in order to introduce her text implies that a male professor will be accepted as a more persuasive authority over her text than herself. Posing as someone else in order to write about herself in the third person enables Slater to create another platform from which to ask her reader to take her text seriously and on its own terms.[38]

Many readers struggle to accept *Lying* on this basis. Rebecca Mead, reviewer for *The New York Times,* fell into the trap of a diagnostic mode of reading, declaring that, upon reading the introduction to Lying, she 'was on the telephone to U.S.C. to confirm [her] suspicion that there is no such person as Hayward Krieger before [she'd] even begun the first chapter.'[39] Similarly Richard Ingram also conducted such 'detective work' trying to track down Krieger, whilst – somewhat perversely – acknowledging that doing so ignores his/Slater's advice to 'embrace the truth of confusion.'[40] Both of these acts were unnecessary given that later in the memoir, under the guise of Neu and Robinson's article, Slater tells the reader that they 'have been unable to locate or confirm the existence of any Hayward Krieger, which is not surprising,' given her tendencies towards mythomania (p. 101). This demonstrates the fruitlessness of Mead and Ingram's mode of reading: they neither catch Slater out, nor make any discovery that Slater has not already signposted to the reader; rather their pedantic investigations merely demonstrate a reluctance to read the text on its own terms, as spelled out by Krieger and Slater.[41]

Slater's *Lying* complicates and develops Gilmore's hypothesis – that we can learn more about the vulnerabilities at the core of autobiography through analysing fakes – by directly engaging with its own fakery; the irony being that, in doing so, the text stops being a fake. Slater uses *Lying* to highlight the issues that arise from the publication and reception of fakes:

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[38] The controversy over Krieger's existence deepened when Slater wrote into *The New York Times* posing as Krieger declaring himself a real person. Whilst the newspaper decided not to publish the letter, some philosophers started quoting Krieger, and gave him an email address as part of a thought experiment. See Culhane, p. 169.

[39] Rebecca Mead, 'Stranger than Fiction,' *The New York Times*, July 16, 2000 < https://archive.nytimes.com/www.nytimes.com/books/00/07/16/reviews/000716.16mead.html?scp=86&sq=alcoholics%2520anonymous&st=cse> [accessed 16 April 2018], para. 7.

[40] Richard A Ingram, 'Life Plagiarizing Illness: Lauren Slater's Lying,' (2001) < http://nasty.staticred.net/archives/000398.php> [accessed 15 January 2018], para. 6.

[41] For an in-depth analysis of Mead's response to *Lying* see Lisa Diedrich, 'Lying and the Performance of Patienthood,' in *The Patient*, ed. by Kimberly Myers and Harold Schweizer (Lewisburg: Bucknell University Press, 2010), pp. 131-52 (pp. 139-40).

namely, the status of truth in her text, and her own unreliability. Indeed, Slater dedicates an entire chapter, written in the form of a memo to her publisher, to justify the marketing of the text as memoir, rather than fiction. Addressed to Kate Medina, her editor, Slater writes a numbered list that acknowledges the difficulties posed by *Lying* through its purposeful ambiguity and refusal to clarify or resolve itself. Positioning Kate as another version of the reader, Slater pleads that she, and we, accept the memoir's inherent contradictions and recognise its value:

> Come with me, Kate. Come with me, reader. I am toying with you, yes, but for a real reason. I am asking you to enter the confusion with me, to give up the ground with me, because sometime that frightening floaty place is really the truest of all. (p. 163)

It is in the juxtaposition of 'toying/floaty' with 'real/true' that *Lying* writes a politicised message into its textual playfulness, stressing that the memoir is not simply about evasion or (dis)honesty but is rather a productive way of *facing* the truths of mental illness and its treatments. And in asking her readers to 'give up the ground with me', and not '*for* me', Slater makes it clear that there is a reciprocity, even arguably a complicity, involved in confronting such formations. This suggestion of a shared space between author and reader is a call for community – 'together we will journey. We are disoriented, and all we ever really want is a hand to hold' (p. 163) – with the resulting communal energy offering the possibility of engaging with the 'frightening' truths raised by questions of mental health.

For Slater, whilst she claims to be 'passionately dedicated to the truth' (p. 160), accuracy, honesty, empiricism, and truth are not synonymous. Emotional and factual memory, narrative and historical truth, are separate entities, and Slater prioritises the former over the latter, as she declares: 'I am more interested in using invention to get to the heart of things than I am in documenting actual life' (p. 220). Less concerned with narrating past events than with communicating her own subjectivity, Slater did not 'strain' for accuracy but 'struggled, instead, to sculpt a set of metaphors that reflected the ineffable reality of who I am, and then told myself my metaphors just must be true, if not factually, then certainly at some deeper, more resonant level' (p.221). Whilst unreliable narration and experimentation with blurring fact and fiction is, in and of itself, nothing new in the development of life writing in a postmodern era, Slater's appeal that 'we observe what unreliability in nonfiction does to the reader/ writer contract', whether it 'productively bends' it, or 'breaks it all together,'[42] is particularly provocative within the context of a memoir about mental illness because of the writer-patient's perceived lack of credibility. However, to accuse Slater of unreliability or dishonesty, in terms of factual inaccuracy, in relation to either her illness or her memoir, misses the point. Rather, what is more productive is to explore the intricacies of using metaphor as an autobiographical tool.

We can see Slater wrestling with the wider importance of truth and accuracy in the context of memoir through her use of smaller scale metaphors that enact what she is doing at the wider narrative level. As well as the overarching macro-metaphor of epilepsy to stand in for ongoing mental distress and repercussions of trauma, Slater uses numerous micro-metaphors to convey moments of narrative, subjective truth. One such instance occurs when she narrates an episode during childhood in which she purposefully falls into an empty grave at a funeral. By describing the feeling of falling, Slater conveys its sense of freedom and the sensation of release from her mother's constraints. She then describes, and thanks, the many hands that reach down to help her from the grave (itself a metaphor for mental illness), but, emphasising the need for her to help herself, instead makes toeholds in the earth and climbs up. Her emergence from the grave is presented as a birth, 'headfirst… squiggling up, my torso pressed flat against the walls of wet earth' (p. 58), and this marks the transition in the narrative from childhood to early adolescence, as well as alluding to the cycles of death, rebirth, and new life through which recovery from mental illness is often figured. Having conveyed all this through one succinct metaphor, Slater stops and writes 'Not quite' (p. 59). She then continues to explain that, given that this 'is a work of nonfiction, everything in it is

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[42] This quotation was in the afterword of the first publication of *Lying* in the UK under the title of *Spasm*, it was edited out of the later edition. Lauren Slater, *Spasm: A Memoir With Lies* (London: Metheun, 2000), p. 223.

supposed to be true' and 'the essential story should at least aim for accuracy' (p. 59). Slater carries on: 'therefore, I confess […] I didn't really fall into the grave. I was just using a metaphor to try to explain my mental state' (p. 59). The use of 'confess' here clearly plays on the link between morality and genre. Slater proceeds to narrate the '*real* truth' (original italics): that the hearse had engine trouble, the coffin was late, and that she looked into the grave and thought about falling, but restrained. By replacing the metaphorical truth with (presumed) historical accuracy, Slater demonstrates what is lost when metaphor is undone in favour of the empirical.

With regards to Slater's controversial use of metaphor, G. Thomas Couser argues that the *Lying*'s ethical difficulties do not stem from Slater's fraught relationship with truth, but specifically from her appropriation of epilepsy.[43] Whilst fully 'endors[ing] the right to write in the metaphorical mode' and 'to stretch the autobiographical pact to the breaking point', Couser argues that, regardless of whether or not Slater is epileptic, *Lying* is unethical because its representation of epilepsy further mystifies a frequently misunderstood disability and consequently will have repercussions on what he terms 'the community of people with epilepsy' (p. 147) and how they are perceived. Couser reductively interprets Slater's use of metaphor as a way by which to protect the privacy of her family members (pp. 147-48), for which he praises her, but states that this comes at the cost of making people with epilepsy vulnerable to misinterpretation. His critique could hardly be more damning:

> she can be criticized for ignoring the rights and interests of people with epilepsy, who suffer from her remystification of a condition still in the process of being demystified. Her disregard for the larger community of people with such conditions is all more remarkable, and culpable, in someone who is a professional therapist. (p. 152)

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[43] G. Thomas Couser, 'Disability as Metaphor', *Prose Studies: History, Theory, Criticism,* 27 (2005), 141-54 (p. 149). This view is in line with David Mitchell's argument that disability metaphors have a negative 'cumulative impact on cultural attitudes toward disabled people.' See David Mitchell, 'Narrative Prosthesis and the Materiality of Metaphor', in *Disability Studies: Enabling the Humanities,* ed. by Sharon Snyder, Brenda Brueggemann, and Rosemarie Garland-Thomson (New York: MLA, 2002), pp. 15-30 (p. 24).

Part of Couser's criticism here stems from his argument that 'the implication of her trope is that epilepsy is, leads to, or is tantamount to mental illness, or at least a personality disorder' (p. 151) and that this further stigmatises the condition. I fundamentally disagree with Couser's argument that Slater implies that epilepsy is equivalent to a mental illness; I am also uncomfortable with his separation of personality disorders from the umbrella of mental illness, and want to emphasise that, if epilepsy is tainted by an association with mental illness (not that I think Slater does this), then we need to think harder about the stigmatization of mental illnesses that underlies this assumption. Whilst much more sophisticated than the readings of Mead and Ingram, Couser's criticism of *Lying* still demonstrates a refusal to take the memoir on its own terms. Granted, this is because Couser fears for the wellbeing of people with epilepsy; however his analysis neglects the fact that communicating experiences of disability, illness, and distress through metaphor is a political, and therefore potentially productive, act.

Responding to Couser, Lindsey Grubbs, whose brilliant article I will return to later, invokes the work of numerous disability scholars who support the use of metaphor as a transgressive and political tool.[44] Jay Dolmage, for example, has demonstrated how discourse about disability is principally written in a medical context, the prose of which is presented as literal and non-metaphorical, and objectifies the people it documents and claims to represent. Such language, he continues, has 'inscribed and controlled the experience of disability for disabled and non-disabled alike.'[45] Dolmage therefore argues that using metaphor to convey the experience of disability not only shuns this register of language, and acts as a tool for understanding another's mind, but also creates 'new knowledge that demystifies the experience of being human and expands understanding by broadening perspectives.'[46] In a similar vein, Amy Vidali has also called for 'a disability approach to metaphor that […] refrains

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[44] Lindsey Grubbs, 'Lauren Slater and the Experts: Malingering, Masquerade, and the Disciplinary Control of Diagnosis,' *Literature and Medicine*, 33.1 (2015), 23-51.

[45] Jay Dolmage, 'Between the Valley and the Field', *Prose Studies,* 27 (2005), 108-19 (108).

[46] Dolmage, p. 108; p. 116.

from policing metaphor; encourages transgression from the disability community; and invites creative and historic reinterpretations of metaphor.'[47] Such theorisations of the potential of the metaphor from within critical and cultural disability studies support Slater's bold and transgressive, albeit risky, strategy.

It is important to emphasise that epilepsy and Munchausen's are not the only illnesses that Slater uses as metaphors in *Lying.* Later on in the memoir she finds comfort in the source of an Alcoholics Anonymous support group. Seeking solace, Slater enters a church and inadvertently sits in on an AA meeting. Feeling welcomed by the community, she continues to attend and is gradually brought into the centre of the group. Flummoxed when asked for how long she had been sober, Slater replies seven months, on the basis that it had been seven months since her relationship had ended with her abusive ex-boyfriend and since her last seizure, both of which had been 'addiction[s]' (p. 181) for her. Soon Slater becomes too 'tangled in the lie' (p. 183), and too reliant upon the support AA that provides to admit that she is not an alcoholic, but epileptic, or not epileptic but Munchausen's, or not Munchausen's, but something else undefined. Cataloguing the similarities between alcoholism and her own experiences – addiction, fear of relapse, manipulation, obsession – Slater draws an equivalence between how they 'had tried to fill' the 'hole in [their] souls' with alcohol, while she 'had tried to fill [it] with the intoxicant of illness, the intoxicant of tall tales, the intoxicant of attention' (p. 187). Alcoholism comes to stand in for epilepsy in 'the same way [that] epilepsy can stand in for depression, for disintegration, for self-hatred, for the unspeakable dirt between a mother and a daughter' (p. 203). Metaphor and indirection are necessary in both cases because Slater '[does] not know how to say the pain directly, [she] never [has]' (p. 204). They enable the conveyance of pain that would otherwise remain untold. Ironically, when Slater attempts to come clean and tell the group that she is not an alcoholic, they silence her confession. Feeling guilty and fraudulent, Slater confesses 'I don't think I am really an

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[47] Amy Vidali, 'Seeing What We Know: Disability and Theories of Metaphor', *Journal of Literary & Cultural Disability Studies,* 4 (2010), 33-54 (p. 34).

alcoholic, I don’t have that disease, I’m sorry’ (p.212). However, the other members misinterpret her admission and gently but firmly silence her, stating that she is in denial and, even more ironically, has been overwhelmed by the truth of her disease (pp. 212-13).

Contrastingly, elsewhere in the memoir she highlights how others attempt to force her to confess the “truth” about her different mental states. In an episode that mirrors the power dynamics of Kaysen’s vignette, ‘The Taxi,’ discussed above, in which she questions the authority and legitimacy surrounding the events of her committal, Slater is confronted by a male counsellor who refuses to engage with her metaphors. Self-admittedly ‘confrontational in style,’ the counsellor takes ‘thirty seconds, a minute tops’ (p. 175) to tell Slater that she has never had the operation that she claims to have had, proves that the journal that she presents him with as evidence is a fake, and states that he will not believe her unless she shows him the scar from her operation. Rather than listening to, or trying to engage with the truth (as Slater constitutes it) conveyed through her metaphors, the counsellor instead asks her to talk ‘about why you need to tell this story, what it really means’ (p. 176). But Slater, as she has already told us, has never been able to talk about her experiences directly, and the encounter ends with her description of the onset of seizure symptoms and then subsequent running from the room. This encounter enacts precisely the description of the diagnostic urge that is resisted in the counter-diagnostic mode. In the narrated encounter, Slater’s means of resistance is to physically leave the confrontation; but here the actual narration itself enacts a staging and presentation of what she suggests is an example of how not to read her text. It is therefore ironic that, as I have demonstrated, many responses to *Lying* replicate exactly the diagnostic paradigm that the text challenges.

The struggle for critics approaching *Lying* principally lies in how to handle its multiplicity. There have been numerous feminist readings of the text, and yet even much of this criticism fails to do justice to its complexity. Kate Cantrell argues that Slater’s use of metaphor and other techniques of blurring fact and fiction are refusals to be contained by constraints of gender and genre.[48] Linking Slater's text to the wider confessional genre, Cantrell writes that 'the female confessant undermines the act of truth-telling by challenging what the dominant culture values as "truth."' (p. 8). However, whilst Cantrell works with an exciting premise and highlights some of the gendered dynamics of Slater's refusals and antagonisms, her reading fails to understand the importance of mental illness and trauma to *Lying*. Making no references to Slater's experiences of sexual abuse, or to her multiple diagnoses of mental illness, Cantrell argues that the unspeakable that Slater attempts to capture is 'the habit of lying' (p. 2) and elsewhere refers to 'Lauren's illness, whether it is epilepsy or lying' (p. 12). In doing so, this reading fundamentally misunderstands the memoir, in which assertions of self cannot be separated from the contexts of mental health and trauma.

More sophisticated is Donaldon's article that grapples harder with *Lying*'s complexity. Linking *Lying* to Slater's work in *Opening Skinner's Box*, and its responses, Donaldson adeptly articulates the power relations at work, both in the clinical encounter, and between Slater and her critics. Donaldson continues to argue that it would be a mistake 'to read "epilepsy" as the counter-diagnosis or metaphor that Slater offers in place of or as a substitute for "depression."' *Lying*, she argues 'cannot be reduced to a mental illness memoir dressed up as an epilepsy memoir.'[49] If epilepsy stands for anything concrete, Donaldson asserts, it is Slater's relationship with her mother, rather than any specific medical condition. Whilst I agree with Donaldson that epilepsy cannot be taken as a simple substitute for another diagnostic category, and that this would be an oversimplification (especially given Slater's overt rejection of psychiatric nomenclature), pinning epilepsy purely to Slater's relationship with her mother is equally reductive. It is true that Slater's seizures are intrinsically linked to her mother, either

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[48] Kate Cantrell, 'Lying in All Honesty: Capturing Truth in Women's Confessional Memoir', *Literature in North Queensland,* 40 (2013), 76-86.

[49] Elizabeth J. Donaldson, 'Lauren Slater's Lying: Metaphorical Memoir and Pathological Pathography', *Gender Forum,* 26 (2009), n.a. <http://www.genderforum.org/print/issues/literature-and-medicine-ii/lauren-slaters-lying/?fontsize=2> [accessed 24 June 2015], (para. 17).

through being triggered by her, or described as somehow belonging to her, for example, 'when a seizure rolled through me, it didn't feel like mine; it felt like hers – her ramrod body sweetening into spasm' (p. 24), and in this way Slater hints at experiences of childhood sexual abuse. However, the point of the memoir is that epilepsy does not, and cannot stand in for any one thing. The metaphor is purposefully open and as such can simultaneously represent the composite experiences of multiple and various mental health conditions (each inadequately diagnosed), the trauma of child abuse, the impact of an abusive relationship, shame, and fears of abandonment.

By far the strongest analysis of *Lying* comes in the form of Grubbs' article, to which I referred earlier. As well as countering Couser's reading of Slater's text, Grubbs analyses the memoir through Tobin Siebers' concept of the masquerade in order to complicate the implications of malingering. Malingering, or illness deception, adds yet another dimension to the discussion of (un)reliability, credibility, and testimony taking place in this chapter; especially given that the concept of lying about disability is so heated in our time of austerity, and subsequent cuts to allowances and benefits. Siebers' version of masquerade is the exacerbated performance of an actual disability as a political and pragmatic strategy – for example, wearing a hearing aid purely to indicate that you are deaf (as opposed to an aid that is needed as prosthesis).[50] Borrowing from Siebers, Grubbs' nuanced reading of *Lying* interprets Slater's use of metaphor as a way of 'exaggerating or performing [Slater's] mental disability […] in a text that transgressively displays its refusal to follow the rules in a society that values ability, and which reads physical impairment as more "legitimate" than mental' (p. 42). Slater makes her impairments and experiences of trauma visible by rendering them physical.

Part of the strength of Grubbs' article comes from its identification with feminist disability studies because this is what allows her to incorporate so many different strands of

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[50] Tobin Siebers, *Disability Theory* (Ann Arbor: University of Michigan Press, 2008), pp. 96-119.

critical interest and recognise and manipulate Slater's multiplicity. In its disentangling of feminism, mental disability, and psychiatric authority, Grubbs' article is exactly the kind of work that belongs under the umbrellas of feminist psychiatric disability studies and the critical interdisciplinary medical humanities. Whilst she achieves this by comparing critical responses to *Opening Skinner's Box* and *Lying*, my own work seeks to negotiate and showcase the memoir's complexity by placing it in comparison with other feminist narratives of illness that, in the case of *Girl, Interrupted* also complicate a diagnostic mode of reading, and, looking forward to *My Body is a Book of Rules*, use formal innovation to reflect on the writer's relationship to reliability and legitimacy, both within the text and through it.

Girl, Interrupted and *Lying* work so well in conversation with each other because they are both subversive narratives that challenge the authority and applicability of diagnoses. This dissatisfaction with diagnoses results in a playful obstinacy in both memoirs that demands that the reader think about mental illness with nuance and complexity. The fact that drawing attention to the limitations of the diagnostic process frequently incurs vitriol, reminds us that it is a political act. Remembering Wilson and Beresford's protest that 'the categorization and classification of our mental and emotional distress has served no useful purpose […]. Our experience of mental and emotional distress does not fit neatly with psychiatry's classificatory system,'[51] Slater and Kaysen's memoirs take on another dimension. *Girl, Interrupted* and *Lying* both demonstrate and then critique the constructed nature of diagnosis, its universality in mental health care, and its use as a narrative vehicle. Self-conscious about their rejection of diagnosis, both writers anticipate doubt from their readers and pre-emptively assert their authority to tell their tales differently. In their textual complexity *Girl, Interrupted* and *Lying* also draw attention to reading practices; by remaining elusive, playfully unreliable, and purposefully difficult, both writers consistently refuse to be easily contained within narrative

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[51] Anne Wilson and Peter Beresofrd, 'Madness, Distress, and Postmodernity: Putting the Record Straight' in *Disability/postmodernity: Embodying Disability Theory*, eds. Marian Corker and Tom Shakespeare (London: Continuum, 2002), pp. 143-157 (p. 146).

templates and counter their readers' diagnostic urge to neatly summarise and solve their experiences of mental illness.

So far my discussions of feminist resistance to the dominant frameworks of illness narratives has been grounded in texts that are well known, amongst popular and/or critical audiences. The next section of this chapter further develops my arguments through an engagement with how a female writer engages with her perceived unreliability and subsequent threatened authority when narrating her story of mental illness in a text that has not yet, at time of writing, received any published critical attention. Although she does not locate herself in this emerging tradition of wilful female memoirists, Washuta further develops the strategies deployed by Kaysen and Slater in her memoir *My Body is a Book of Rules.* This is despite the fact that, in contrast to the other two memoirists in this chapter, Washuta unconditionally accepts her diagnosis of bipolar disorder. However, whilst her motivations for creating a fragmented, disrupted, and interrupted narrative may differ, her self-consciousness in the construction of such a text bears remarkable resemblances with the other two writers.

My Body is a Book of Rules

Elissa Washuta's *My Body is a Book of Rules* is a coming-of-age memoir about the entangled nature of her diagnosis of bipolar disorder, relationship with disordered eating, experiences of rape and sexual assault, and heritage as a mixed race Native American member of the Cowlitz tribe. Throughout the text Washuta explores the interwoven nature of her mental health, sexual trauma, and ethnicity, foregrounding the interconnections and reciprocity between the various strands of her identity and her personal and tribal histories. Like *Girl, Interrupted* and *Lying*, *My Body is a Book of Rules* is a memoir that crafts multiple worries about legitimacy, reliability, and credibility. Washuta details numerous relationships with different health care professionals and their search for a diagnosis that would make sense of her mental states, as well as drugs that would stabilise them. Unlike Kaysen and Slater, Washuta identifies with her diagnosis of bipolar and finds it a useful framework to explain her oscillating moods as well as giving her access to medications that (eventually) help control her symptoms. However, as with the other authors discussed in this chapter, Washuta finds that her diagnosis is mobilized against her to undermine her authority. Like Slater, Washuta is anxious about her experiences of sexual violence being doubted and disbelieved, although, as I will analyse, this anxiety manifests differently in her memoir's form. Washuta also has the additional insecurities over claiming her status as a Native American because of her mixed-race heritage. An enrolled member of the Cowlitz tribe, but able to pass for white, Washuta frequently encounters questions about the legitimacy of her indigeneity. Attentive to the enmeshment of these experiences and histories, my analysis of *My Body is a Book of Rules* is grounded in a commitment to intersectionality.

I began this chapter outlining what a feminist psychiatric disability studies might look like and the kinds of work it could do. Referencing Nicki, I emphasised the interconnections between mental illness and trauma, particularly sexual violence. Citing Mollow's analysis of Danquah's memoir, I established the importance of criticism that heeds multiple forms of oppression, particularly how experiences of mental illness (and access to treatments) are shaped by gender, disability, and race. By introducing this chapter with my intersectional framework, and explicitly returning to intersectionality here, I acknowledge the fact that 'experiences and representations of disability [and mental illness] are always inflected by other categories'.[52] In my analysis of *My Body is a Book of Rules*, I am not simply (and reductively) adding race to the discussion in the hope of achieving a more '"complete list" of categories',[53] but to recognise the ways in which Washuta's experiences of mental illness and sexual violence are shaped by her indigeneity. Writing about 'Disability and the Edges of Intersectionality,' Alison Kafer and Eunjung Kim argue that 'scholarship that attends *only* to

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[52] Alison Kafer and Eunjung Kim, 'Disability and the Edges of Intersectionality', in *The Cambridge Companion to Literature and Disability*, ed. by Clare Barker and Stuart Murray (Cambridge, Cambridge University Press, 2018), pp. 123-38 (p. 124).

[53] Ibid.

disability, casting it as separate from processes of racialization or histories of colonialism, reproduces oppressive norms'.[54] Failing to acknowledge the impact that being Native American has on Washuta's interpretations of her mental illness and sexual trauma would be unethical and miss the sophistication at work in the memoir.

My Body is a Book of Rules is the most formally experimental memoir in this chapter. Lenape scholar Joanne Barker and I-Kiribati scholar Teresia Teaiwa write that 'Indigenous peoples understand that there is no difference between the telling and the material. They understand how we all, in fact, live inside and through the narratives we tell'.[55] Introducing their recent edited collection on Native nonfiction, Washuta and Theresa Warburton, from Lummi/Coast Salish territory, argue that form is a particularly Native concern. Linking the basket, body, canoe, and page, they stress how

> each of these vessels has a form, a shape to which its purpose is intimately related. Each carries, each holds, and each transports. However, none of these vessels can be defined solely by their contents; […] the craft involved in creating such a vessel […] is inseparable from the contents that the vessel holds.[56]

Form and content are intimately and intrinsically related, and this relationship is celebrated, rather than taken for granted. Warburton and Washuta go on to write that being attentive to the form of Native literatures is especially important because works by Native writers, particularly works of nonfiction, have predominantly been read through an ethnographic lens focused on extracting information about Native lives. Emphasising the importance of form and how it moulds content shifts criticism away from 'the colonial demand for factual information about Native life' and towards 'a framework that insists upon indigeneity as a dynamic, creative, and intentional form which shapes the content that is garnered through its

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[54] Ibid.

[55] Joanne Barker and Teresia Teaiwa, 'Native InFormation', in *Reading Native American Women: Critical/Creative Representations*, ed. by Inés Hernández-Avila (Oxford: Altamira Press, 2005), pp. 107-28 (p. 108).

[56] Elissa Washuta and Theresa Warburton, 'Introduction', in *Shapes of Native Nonfiction: Collected Essays by Contemporary Writers*, ed. by Elissa Washuta and Theresa Warburton (Seattle: University of Washington Press, 2019), pp. 3-22 (pp. 3-4).

exploration'.[57] Given the dynamism and formal innovation that characterises much Native nonfiction, its absence from critical discussions about the contemporary American memoir is especially marked.

Washuta and Warburton's introduction to their edited collection of Native nonfiction helps to contextualise the formal experimentation that underpins *My Body is a Book of Rules*. Even more so than the other texts in this chapter, Washuta's memoir eschews any linear or chronological sense of trajectory. *My Body is a Book of Rules* is a collection of interlinked, but self-contained essays. Interspersed throughout the memoir, not dissimilarly to how Kaysen threads photocopies of her medical records throughout the narrative of *Girl, Interrupted*, Washuta writes 'A Cascade Autobiography', which focuses on the historical traumas of her tribe and her contemporary experiences of being Native American. Unlike the other essays in the memoir, the vignettes that make up The Cascade Autobiography are numbered sequentially and run throughout the memoir as a spine, holding the rest of the writing in place. Washuta's other essays focus on her experiences of mental illness and sexual trauma. These essays have been referred to as 'hermit crab essays' because of the way Washuta borrows an existing structure and makes her content fit the form.[58] For example, Washuta's essays take the various formats of a letter; Q&As from *Cosmopolitan*; lists; an annotated bibliography; diary entries; a journal article; a hypothetical transcript of the television show *Law & Order*; and a dating profile. They also include multiple different kinds of texts and layouts, including interviews conducted by Washuta, transcripts of her Instant Messaging, short stories, material from her rapist's blog, as well as extracts from autobiographies of other Native Americans, historical letters, and the *DSM*. These multiple texts and formats provide Washuta with different ways of getting at, grappling with, and structuring her experiences, and, together, create a body of documentation that bears witness to them.

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[57] Ibid., p. 5.

[58] Chip Livingston, 'Funny, You Don't Look Like (My Preconceived Ideas of) an Essay', in *Shapes of Native Nonfiction*, ed. by Warbuton and Washuta, pp. 39-52 (p. 48).

My Body is a Book or Rules self-consciously reflects on Washuta's agency at various times of her life, and in the telling of that life. Her memoir provides a platform to "work through" the intricacies and difficulties of her mental illness, trauma, and their overlaps. Work through is a productive term because it depicts the labour that went into the production of the narrative as well as describing the labour that the narrative does. In the memoir, Washuta writes, 'it used to be hard to tell the truth. I teased it out of myself, a necessary process' (p. 118), indicating the painstaking effort that was required to extract and structure these memories. Taking the opposite approach to Slater's mobilisation of lying, *My Body is a Book of Rules* is a project of excavation for Washuta in which she repeatedly engages with her mental illnesses and symptoms, returns to and reformulates the scene of the rape and reflects on how it has impacted the rest of her life, and traces histories of ancestral violence. Indeed the memoir's structure is that of repeatedly returning to and finding a new way to expand and unpack memories of illness and abuse.

Like Kaysen and Slater, Washuta's formal experimentation calls attention to issues of authority and power in the context of mental health care. The essay 'Note' takes the form of a letter from her psychiatrist that provides details from her medical records. Addressed from the Health centre of the University of Maryland to that of the University of Washington, it opens by saying that 'the patient' had requested access to her medical records as proof of her diagnosis and treatment to facilitate her transition between universities. Because 'the patient' (it only refers to Washuta by name once at the very end of the letter) may be upset by some of the content of those records, the psychiatrist agreed to write this note instead. The psychiatrist then goes onto trace the introductions, discontinuations, and combinations of prescription drugs including Lexapro, Wellbutrin, PRN Ativan, Ritalin, Lamictal, Lithium, Abilify, and Klonopin, and the change of her diagnosis from severe depression and anxiety to bipolar, mixed disorder.[59] The tone of the letter is jarring, including numerous inappropriate comments

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[59] Elissa Washuta, *My Body is a Book of Rules* (Pasadena, CA: Red Hen Press, 2014), pp. 9-13.

such as ‘I disclosed to the patient that she was my favourite patient’ (p. 10); ‘the patient’s level of composure and charisma during office visits made it difficult to believe she was so fucked up’ (p. 12) (the tone of which is reminiscent of Kaysen’s glib sarcasm); and states that they ‘missed her a lot when she left’ (p. 13). It is also strangely acerbic when talking about diagnoses and prescriptions, for example prescribing Ritalin regardless of the risk that Washuta might insufflate it, the psychiatrist writes ‘I had to disregard any far-out notions about what abuses she might be doing to the linings of her nostrils in favor of keeping the sheen on her GPA’ (p. 11) and, critiquing the arbitrariness of Patient Health Questionnaire-9 type tests (a questionnaire to determine depression), writes ‘we decided that the patient hated herself. We diagnosed her with “severe unipolar depression.” While that was true at that moment, in other moments, she thought she was a rapper so famous she didn’t need the ability to rap’ (p. 11). These comments are put into context when the letter is signed ‘The Psychiatrist[1]’ with the footnote ‘with edits from Elissa Washuta, 11/13/2007.’ Like Slater’s meta-introduction supposedly by Professor Krieger, or her journal article apparently by Neu and Robinson, Washuta plays with the malleability of documents and textual modes, calling attention to issues of authority and, also like Slater, self-consciously signals when she does this.

Washuta expands on her medical interventions in the chapter ‘Prescribing Information’. She lists the medication that she has been prescribed alongside the date of prescription and quantity of dosage, for example ‘**8/26/06 ESCITALOPRAM OXALATE (LEXAPRO) 5 MG TABS**’ (p 53). She appropriates the language and format of the text written on the side of pill bottles and blends it with personal anecdotes about the purpose, use, and side effects of each of the medications. Detailing twelve drugs over two years, Washuta traces her and her health professionals’ search for the combination of drugs that would stabilize her moods. Experiencing extreme weight loss, followed by excessive weight gain, a life-threatening rash, restlessness, and insomnia before finding the combination of medications (Seroquel, Lexapro and lithium) that work for her, Washuta details the struggles of remaining drug complaint whilst emphasising the absolute necessity of doing so.

Finally, Washuta provides her own version of an annotated diagnosis. In the chapter 'Many Famous People Suffer from Bipolar Disorder,' she contrasts '**THE DEPRESSIVE EPISODE EXEMPLIFIED BY THE LIFE OF KURT COBAIN**' and '**THE MANIC EPISODE EXEMPLIFIED BY THE LIFE OF BRITNEY SPEARS**' with '**THE BIPOLAR MIXED STATE EXEMPLIFIED BY THE LIFE OF ELISSA WASHUTA**' (p. 139). Underneath subheadings that mimic the language of a diagnostic manual – '*IN BIPOLAR PATIENTS, MANIC EPISODES MAY BE TRIGGERED BY SCHEDULE CHANGES*' (p. 131) – Washuta compares the public histories of Cobain and Spears' mental illnesses and catalogues them. She then, like Kaysen, copies out and annotates her own diagnosis from the *DSM*-4 'I am 296.62. My brain – my swirls of dusty glitter, my gray matter wrung like a sponge – are summed up in a five-digit number' (p. 140). 296 are the first three digits for a bipolar 1 disorder, 6 indicates a mixed episode (one that combines both mania and major depression), and the 2 indicates moderate severity. Whilst the five digit number may feel reductive, Washuta, unlike Kaysen and Slater, identifies with her diagnosis; she writes that when her doctor 'finally put his finger on the bipolar diagnosis, pulled there like a knowing planchette skidding across an Ouija board to a spectral message, I felt relieved to have finally arrived at an answer' (p. 155). Whilst Slater rejected diagnoses outright as means of self-identification, and Kaysen struggled over how much she identified with her diagnosis of borderline personality disorder, Washuta does not challenge her diagnosis of bipolar disorder. The ease with which she identifies as bipolar is contrasted with the difficulty she has in claiming the label of rape survivor, which took over a year, and repeated reassurance from therapists and counsellors. It is also contrasted with the fraught process that she went through before being able to identify comfortably and confidently as a Native American; she writes: 'I am bipolar in a way that real Indians are really Indian: at thirteen, I knew I was bipolar without being told, before anyone else caught on' (p. 179). Being bipolar is framed as an essential part of Washuta's selfhood.

The only way that Washuta problematises her bipolar diagnosis is in relation to how it fits with her Native American heritage. One of the strongest indicators of bipolar disorder is a family history of it, and yet Washuta is the first person in her family to receive the diagnosis. When her psychiatrist asks her to 'think hard' (p. 158) about her family history and whether there are any signs of behaviour that could be accounted for by bipolar disorder, Washuta adamantly replies '"No. […] it had to have started with me"' (p. 158). In doing so she refuses to tell her doctors about Abbie, her great-grandmother, arming herself with scissors during her pregnancy to prevent any white women assisting the birth of Washuta's grandmother, and her later suicide, or her great-grandfather's alcoholism (p. 179). She does this for two reasons. Firstly, 'bipolar has the clinical film of a white man's intervention' (p. 179), and retrospectively diagnosing her Native ancestors would be a colonising act – behaviour resulting from the historical trauma experienced by her Native American predecessors should not be categorised and explained by the labels of the *DSM*.[60] Writing about health inequalities and therapeutic treatments available to Native American communities, Eduardo Duran, Bonnie Duran, Maria Yellow Horse Brave-Heart, and Susan Yellow Horse-Davis use the category of 'chronic and acute reactions to colonialism' rather than 'standard diagnosing practices,' and labels, in order to avoid 'the invalidation of the pain and suffering that is directly connected to centuries of genocide.'[61] Secondly, bipolar becomes such an inherent part of Washuta's identity that she

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[60] Instead such behaviour could be better described as part of a 'soul wound', the term coined in academic literature by Native American psychologist Eduardo Duran and Native American scholar Bonnie Duran. It can be used synonymously with historical trauma (which is more common in contemporary scholarship) and inter-generational post-traumatic stress disorder. See: Eduardo Duran and Bonnie Duran, *Native American Postcolonial Psychology* (Albany: State University of New York Press, 1995) and Eduardo Duran, *Healing the Soul Wound: Counselling with American Indians and Other Native People* (New York: Teachers College Press, 2006).

[61] Edurado Duran, Bonnie Duran, Maria Yellow Horse Brave Heart, and Susan Yellow Horse-Davis, 'Healing the American Indian Soul Wound' in *Intergenerational Handboook of Multigenerational Legacies of Trauma,* ed. Yael Danieli (New York: Plenum Press, 1998), pp. 341-54 (p. 346).

does not want to share it with anyone else: ‘I didn’t want to reach back and find that I had to share this with some stranger. I wanted my brain to be only mine’ (p.158).

As well as examining her history of mental illness, Washuta excavates her experiences of sexual trauma. When she was twenty, Washuta lost her virginity by a rape. She was in a relationship with the perpetrator at the time, and had engaged in other consensual sexual acts, but did not agree to have sex with him. In the aftermath of the event Washuta struggled to come to terms with what had happened. When the doctor who gave her the morning after pill suggested that she had been taken advantage of, Washuta replies that she does not understand the complexities of the situation and leaves. Confused and upset by what had happened, and unable to process the violence that she had experienced, Washuta repressed the memories of the encounter and tried to convince herself that it had been consensual.[62] She writes that ‘[she] forgot so much, but in the years following, [she] began to remember,’(p. 95) and that ‘[she] tried so hard to forget it, called it consensual a thousand times, but here it was, feeling like rotten meat in [her] stomach’ (p. 127). It is only years after the event that Washuta actively remembers and comes to terms with the sexual violence; and the writing of the memoir is an integral part of these acts of processing. Unsure of her own authority and unable to be a witness to herself at the time of the rape’s occurrence, *My Body is a Book of Rules* is another example of Washuta’s working through; her labour to contextualise the rape in a self-narrative, as well as a text that undertakes that contextualising work.

It has long been argued that trauma, by definition, cannot be assimilated at the time of its occurrence, and subsequently comes back to the victim in fragments.[63] Washuta’s memoir’s episodic and multimodal form is appropriate to capturing the fraught processes of remembering, working through, and coming to terms with the rape and sexual assault. She

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[62] For scholarship on the complexities of rape see Nicole Gavey, *Just Sex? The Cultural Scaffolding of Rape* (Hove: Routledge, 2005).

[63] See Cathy Caruth, *Unclaimed Experience: Trauma, Narrative, and History* (London: John Hopkins University Press, 1996) and Roger Luckhurst, *The Trauma Question* (London: Routledge, 2008).

states that, ‘After the work [her] brain did to deny the ordeal, [she] had to actively put the facts back together if [she] was to resolve anything at all’ (p. 126). I will return to the issue of resolution later, but for the moment I will explore how the memoir traces and enacts this “putting back together.” It is important to note that, whilst this memoir narrates trauma, it differs from some of the chief expectations of a trauma narrative. Jean-Michel Ganteau and Susana Onega explain how

> trauma narratives, fictional or not, are often seen to be characterised by the inability to voice a trauma, and they tend to limit themselves to indirect evocation, beating about the hole that they must be content to circumscribe, short of describing it. More often than not, trauma narratives must renounce the possibility of describing the unassimilated traumatic memory and build their impossibility into the textual fabric, performing the void instead of anatomising it.[64]

We have seen this in action with Slater’s *Lying*: unable to voice the experiences of abuse directly, Slater uses metaphor and documentation to indirectly evoke the trauma. *Lying* performs the difficulty and anxiety of communicating traumatic incidents, and in the next chapter, we will see how this characterization of trauma narratives – with their inability and refusal to voice the trauma directly – also applies to Alexander Masters’ *Stuart: A Life Backwards* (2005). In the final chapter I will analyse the ways in which Katie Green both depicts and obscures her experiences of sexual abuse in her graphic memoir *Lighter than my Shadow* (2012). In *My Body is a Book of Rules*, rather than circumnavigating her trauma, Washuta anatomises it. Multiple essays, comprised of different kinds of writing and document, provide her with numerous ways of dissecting the events and trying to “put them back together,” to witness them, and to “work through” them. They also provide Washuta with a space to think through her reliability, credibility, and authority, and how these are read by others. Having recovered memories of her trauma and compiled them in a self-narrative, Washuta creates

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[64] Jean-Michel Ganteau and Susana Onega, ‘Introduction: Performing the Void: Liminality and the Ethics of Form in Contemporary Trauma Narratives,’ in *Contemporary Trauma Narratives: Liminality and Ethics of Form,* ed. by Susana Onega and Jean-Michel Ganteau (London: Routledge, 2014), pp. 1-20 (p. 10).

structures of testimony that anticipate responses that question and doubt her credibility, and pre-emptively answers them.

Rape is one of the most violent ways in which a person's authority can be ignored. Washuta first reveals that she has been raped in a vignette that is a list of all of the people that she has had sex with in reverse chronological order. Counting down from 24 to 1, Washuta itemises each of her sexual partners, as a tally chart, with anecdotes. Whilst a few depict moments of mutual care, the majority are manipulative and abusive, and these culminate in the rape: 'I play the scene over in my head, as though I could improve upon it in my thoughts. But still, in every remembering, in the middle of the night you are on top of me. Still, every time, I say no, you say yes, and to you, it is nothing but a difference of opinion' (p. 38). This counting down provides an obvious example of Washuta working through her memories of sexual partners in order to get to the rape. Systematically going back through her sexual encounters in this way enacts a working up to being able to vocalise the original moment of rape, which is then positioned as the root of her abusive sexual history.

Washuta returns to the rape in a chapter entitled 'Fucker and Fucked,' which is structured as a pseudo-academic paper that analyses the terms used by ten undergraduates to describe their sexual encounters. Interviewing these students, Washuta performs a critical discourse analysis to explore the symmetry and agency in the terms used by individuals to describe the sexual activities that they, or people they know, have been involved in. Exploring the differences between terms such as '*have sex, fuck, sleep with,* and *do*' (p. 73), Washuta analyses the power dynamics implied by each term – noting whether both parties are active in the encounter, or one passive and the other active; she also discusses how much detail a given term reveals – 'hooked up with,' for example, is vague and encompasses numerous acts not limited to penetration. The paper is laid out like a journal article, with subheadings such as '**WE HOOKED UP OR WHATEVER: A RECENT DEVELOPMENT OF THE LANGUAGE OF SEX**,' and uses footnotes. In some cases the footnotes provide references to further scholarship, but more frequently Washuta uses them to interject anecdotes about the participants and her (frequently sexual) relationships with them, provide commentary about campus sex culture and student expectations, and reveal her own sexual history, including the rape.

The precision of language use to describe a sexual act is particularly important to Washuta because of the power dynamics implied. Accordingly, she refuses to use the term 'hook up' because of its ambiguity, instead: '**6.** […] If I fucked him, that's what I would say, that I fucked him. If he came on my belly before we could fuck, that's what I'd say' (p. 74). Here Washuta assures her reader that she is prepared to use the exact terms to describe a sexual encounter. This directness is fundamental to Washuta's testimony of the rape; she does not leave herself open to accusations of ambiguity that could be mobilised to undermine her authority and acquit the perpetrator. The linguistic focus of the paper, and therefore chapter, provides a way for Washuta to reflect on the status of the rape. Noting that none of the interviewees referred to themselves as occupying a passive role or used statements like "He had sex with me," Washuta inserts a footnote: '**37.** The boy who raped me had sex with me: that was my whole problem. That was my obsession. None of this insanity would have happened if I'd […] been less fucked from the outset of my sexual history' (p. 85). Washuta frames her passivity as central to the encounter's status as rape. Her directness continues as she engages with the aggression that she experienced: '**39.** […] But he did fuck this bitch. He came on this belly, came in this mouth, came in this cunt' (p. 85). The use of 'this,' rather than 'my', objectifies Washuta's body and distances herself from it. Reflecting on the asymmetry of terms from the 1970s to the present day, Washuta inserts another footnote:

> **44** Thus, I would never say "Elissa did it to Damian," although I would tell myself too many times during long nights, examining my emotional fracture lines, "Damian did it to Elissa." Again, Damian bangs Elissa, Elissa does not bang Damian; Damian humps Elissa, Elissa does not hump Damian. […] Would it be outside the scope of this conversation to ask whether Damian rapes Elissa? Or is that what this discourse analysis was about all along? (p. 87)

Clearly this chapter, structured by the format of the academic paper, acts as a means to reflect on and reveal the power dynamics and aggression that made Washuta's first sexual encounter a rape. It is important that these details are revealed in the footnotes. Washuta talks about the rape directly and precisely, but does so at the literal margins of this chapter. Whilst the normal role of footnotes is to contain material that is supplementary to the body of the argument, here the integral information and central idea is contained in a liminal space at the edge of the page. This both speaks to the amount of work that needs to be undertaken in order to make the rape central, and communicates Washuta's initial hesitancy in how to categorise and vocalise the rape. The academic paper provides a scaffolding that builds an authoritative discussion around sex, consent, and power, on which Washuta can hang her own experiences. Whilst these experiences are framed as apparently incidental to the piece through their placement in the footnotes, they are in fact the main purpose for the discussion and Washuta ensures that her reader has realised this through her direct, knowing and self-conscious question 'or is that what this discourse analysis was about all along?' Clearly the answer is yes. Her direct questions to the reader here, similar in many respects to how Kaysen and Slater interact with their audience, reframe the chapter as an explanation and justification to the reader of why Washuta's experiences constitute rape, and dare them to disagree.

Washuta further develops her use of footnotes in the chapter 'Actually-'. As with 'Fucker and Fucked,' she interrupts and annotates the body of the text through footnotes; however here the material of the footnotes is an Instant Message conversation that took place between her and a friend Noah the morning after the rape (Figure 1). As with Kaysen's juxtaposition of two kinds of life writing in *Girl, Interrupted* – one, the medical record written about her at the time of events, the other written by her retrospectively – Washuta creates a similar effect, but rather than juxtaposing her authority with someone else's to ask the reader who they believe, Washuta contrasts two sources both by her, one (the IM conversation) from the time and one (the narrative) retrospective. The juxtaposition of the two sources of life writing is stark on the page as the footnotes encroach upon the body of the text, often taking up more space than the narrative. The way in which they interrupt the narrative is purposefully disruptive and creates a jarring contrast between the controlled retrospective narration, and the distress and confusion from the time. Contained in footnotes, the Instant

Messages are also used to provide evidence to substantiate the retrospective narration of events that has only been made possible by the time and distance from their occurrence, and Washuta's labour to actualise them; they are used to back up the 'faulty memory riddled with

Figure 1: Footnotes and Instant Messages interrupting the narrative, *pp. 118-19*

holes' (p. 118). The formal innovation of these chapters clearly demonstrate the flexibility of the memoir, and the multiple ways in which it can be mobilized to hold testimony.

In *Tainted Witness*, Gilmore argues that 'autobiography is more flexible than legal testimony. Because it permits innovation writers have historically made use of its elasticity to assert legitimacy, to challenge power, and to enable counterpublics to coalesce around life stories.'[65] As well as celebrating the elasticity of the memoir form, Washuta also reflects on the rigidity of the legal process and why she did not report her experiences to the police and pursue a case in court. In 'Sexually Based Offenses,' Washuta imagines what might have happened had she done so. She does this in yet another formally challenging way, by creating a script for a hypothetical episode of *Law & Order: Special Vicitims Unit*, juxtaposing quotations from the television series with her imagined replies. *Law & Order: SVU* is a hit legal and crime drama set in New York that was in its 19th season at the time Washuta was writing. Episodes of the show depict the police procedures and legal work that surround cases of sexual violence. In this chapter Washuta imagines 'how [her] story could be portrayed in episode form, neat, sectioned, with closure' (p. 97). She constructs quotations from the show from the characters Good Cop, Bad Cop, Villain, Psychiatrist, Defence Attorney, and Assistant District Attorney in one column, and writes her replies in italics in another column. Through staging the episode, Washuta attaches criticisms, doubts, and questions to stereotyped characters, to which she can then respond. By staging the criticism and doubt she receives from characters in her imagined episode, Washuta also counters similar responses that a reader might have to her account. The Bad Cop asks questions such as 'Did you tell him to stop?' (p. 98), 'Why not just fight back? […] Did you ever say no?' (p. 99), and repeatedly attempts to undermine Washuta's testimony: 'She's drinking apple martinis to try to lose control and he's drinking Amstel Lights to try to keep it. You going to tell me she's not flirting with him? […] Not exactly the poor, fragile victim we thought she was' (p. 106). The format of

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[65] Gilmore, *Tainted Witness*, p. 9.

the gridded script provides a space in which Washuta can give the responses that she would give had she had the time, space, and ability in real life. The assigning of dialogue to

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Figure 2:The layout of Washuta's Law & Order script, p. 97

caricatured characters also calls attention to the victim blaming and aspersions that are frequently made against sexual assault survivors in attempts to discredit them.

In keeping with the structure of a *Law and Order* episode, Washuta introduces a “twist” when she is assaulted again, three years after the initial rape. Here Washuta focuses on the legal setting and the ways in which her testimony could have been tainted, had she taken her case to court. The Defence Attorney takes over from the Bad Cop in discrediting Washuta, stating: ‘Our complaining witness appears to have a history of emotional problems. Could a manic episode lead her to act out sexually? You put her on the stand, I’ll be forced to bring up her promiscuity. It’s her word against his’ (p. 110). Washuta’s history of mental illness is used to discredit her as a victim. Additionally, as was the case with Kaysen’s “symptom” of “compulsive promiscuity” in *Girl, Interrupted*, Washuta’s sexual agency from other encounters is mobilised against her. Through creating this hypothetical episode, Washuta draws attention to the ways in which the legal system fails to accommodate the testimony of survivors and the emotional difficulties that a survivor faces when testifying. She states that she knew that she would struggle to build a case on the basis that she did not have a physical examination at the time of either her rape or her assault, the difficulty of proving lack of consent, and, in the instance of her assault, the lack of penetration. Washuta’s memoir perfectly illustrates Gilmore’s critical argument that two of the most common and intractable arguments used against women who claim sexual violence, “he said/ she said” and “nobody really knows what happened” (both of which Washuta includes in her episode) ‘deflect a more rigorous engagement with narratives, persons, evidence, and scenes of abuse that are complicated.’[66] As with many survivors of sexual violence, fear of being disbelieved was one of the primary reasons why Washuta did not pursue her case in a legal capacity. In her script she writes ‘*I can’t handle it when someone questions me. I can scream “fuck you” a million times to my pillow, but could never say it to the face of a doubter. It’s not really worth it to pursue this in*

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[66] Gilmore, *Tainted Witness*, p. 6.

court' (p. 111). It is on a literary, rather than legal, platform that Washuta creates a space in which there can be rigorous engagement with her narrative of rape – one that notices and engages with the complications, emotions, and confusion surrounding the events, without undermining the authority of the testifier or doubting her testimony.

Washuta's experiences of rape and sexual assault are contextualised within the history of genocide and sexual violence against indigenous peoples. Native American women are disproportionately likely to experience rape: 'according to the Department of Justice, one in three Native women will be raped during her lifetime. The rate of sexual assault against Native women is more than twice the national average' (p. 168).[67] Consequently, there is a temptation, Washuta recognises, to interpret her rape as part of this wider history of racial hatred and inherited hurt. She writes,

> I had to be *something,* so I searched for an identity to sink into. Before I knew I was bipolar, and could settle into that, I had the rape. It was bloody and violent and it was an injustice of the kind my ancestors knew, I used to think. (p. 178)

However, whilst she contextualises her individual experience of rape amongst the oppression and subjugation of Native American people, Washuta resists making reductive comparisons between her contemporary trauma and that of her ancestors':

> For a while I had to make the rape fit into my life as an Indian. It was nice to have a nice, straightforward, academic explanation to fall back on, one involving a history of violent oppression and subjugation, something about inherited consciousness […]. But the rape wasn't really anything like what happened one hundred and fifty years ago at the Cascades of the Columbia River, because unlike Tumalth's broken-up generation, I got much better.[68] (pp. 178-79)

In her initial distress and confusion surrounding the rape, pinning it to a wider cultural history of abuse provided Washuta some clarity, and a means to interpret what had happened to her. However, as she works through and reorders her memories, associating the violence done to

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[67] For more on the interlinking of colonial violence and rape, and the impact of this on Native American women, see Sarah Deer, *The Beginning and the End of Rape: Confronting Sexual Violence in Native America* (Minneapolis: University of Minnesota Press, 2015).

[68] Tumalth was the first chief of the Watlala band and Washuta's three-times-great-grandfather. He signed a treaty giving up much of his tribe's land and agreeing to move to a reservation, he was later hanged and his family enslaved.

her body with that experienced by her ancestors, she realises, is an oversimplification. The memoir traces Washuta's realisation that, whilst there are interconnections between having been raped and being Native, the historical trauma of her ancestors cannot stand in for, the present of her body. An awareness of her history and inheritance remain crucial to her developing understanding of self, yet they are no substitute for her labour to reclaim her own experiences and identity.

Despite the fact that the grounds for Washuta's disassociation of her rape with the historical trauma is that she 'got much better,' *My Body is a Book of Rules* is not a triumph narrative, nor is it really one of recovery. Rather, as I have suggested, it is a memoir that traces and enacts a process of working through that allows Washuta to come to terms with, and to dictate the terms of her experiences of sexual violence, mental illness, and ethnic identity. Working through and coming to terms with do not imply or provide closure in the same way that overcoming, recovery, or reconciliation do. In the memoir Washuta states that she cannot gain closure over the rape because the only way that closure is framed in Western society is through the legal system, and she has demonstrated why that was not appropriate for her. However, she does not need this designated form of closure in order to claim authority and assert her credibility in the telling of the events. In relation to the rape Washuta writes, 'I don't need to seal off the ordeal into a closed compartment – I moved through it' (p. 127). This moving through is the work that went into producing the memoir, as well as the process enacted by the text. 'With all the memories in place,' Washuta writes, 'one by one, [she] made sure they only hurt [her] when [she] let them' (p. 127). The labour that underpins the memoir is the work to isolate and organise each memory, to put them in place, to, as I quoted earlier, 'put the facts back together' (p. 126). Whilst one might argue this does produce a version of overcoming, it is one that refrains from being conclusive. There is every suggestion that the rape, her mental health, and her status as a mixed race Native American will be issues that Washuta will have to keep coming back to, keep working through, keep coming to terms with, but this does not undermine the work that the memoir undertakes in facilitating these processes and providing a platform for them.[69]

Conclusion

It was not the original intention of this chapter to focus solely on memoirs written by female authors. However, after reading widely across memoirs about mental illness, the texts that I found to be the most experimental, disruptive, and provocative were all written by women. Furthermore, these texts were particularly self-conscious and reflexive about the questions that they raised and the ways in which they could be received and interpreted. Such tendencies towards provocation and reflection are intrinsically linked to issues of authority, testimony, truth, and reliability; all of which are implicitly gendered. Consequently, this chapter focused on the work of female writers of mental health memoirs who, anticipating challenges to their authority, directly engage with the impact of diagnoses and trauma upon their perceived credibility in their capacity to narrate their experiences. I have argued that their self-consciousness – the result of having repeatedly encountered doubtful responses to their testimony – results in wilful texts that challenge the boundaries of memoir as a genre and refuse to adhere to popular and critical neoliberal expectations of the form of the illness narrative. This rebelliousness in their respective memoirs, which, I have emphasised, is not the same as reducing women's experiences of mental illness to madness as gendered rebellion, challenges the reader to engage with the possibilities that arise from a critical openness to uncertainty, confusion, disruption, and interruption.

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[69] A year after I had written the first draft of this chapter, Washuta published an essay in which she returned to these experiences having been given a new diagnosis of post-traumatic stress disorder, and told that it was unlikely that she had ever been bipolar. This illustrates both the contingent nature of diagnosis and an instance of Washuta continuing to work through her relationship with mental illness, trauma, and indigeneity. I will unpack the significance of this essay more fully in the conclusion to this thesis.

All three texts provide a kind of ‘working through’ of the author’s experiences of mental illness. Kaysen’s multimodal methods ultimately point to the way she seeks to reclaim the events of her institutionalisation through actively acknowledging the jarring, fragmentary and often contradictory nature of her experiences. The events do not have to be tidied or resolved in *Girl, Interrupted*, but she has to own their messiness in a way that was inaccessible to her at the time. Slater disorients her reader in a different way. Rather than relying on juxtaposition and interchanging episodes, Slater’s extended metaphor, and repeated plea that we accept it, creates a form of textual stumbling over events and their possible meanings. In doing so it highlights what appears as her own uncertainty as a reader of her mental state and asks the reader to recognise the benefits of this uncertainty and to enter into it with her, rather than impose a categorisation upon the murky set of experiences. Kaysen and Slater make clear that it is in the various indirections of their memoirs’ aesthetics – both formal playfulness and the terms of address the texts make to their readers – that the real complexities of subjectivity, narrative, medicine and diagnosis can be seen to interact.

Washuta’s *My Body is a Book of Rules* also emphasises the importance of formal playfulness and direct engagement with the reader, but rather than focusing on the complex interplay of patient, diagnosis, and psychiatric authority, she highlights the interconnections between and embeddedness of trauma, mental health, and ethnicity. Like Kaysen, Washuta relies on the processes of cutting and juxtaposing episodes and texts within and between chapters, but her version of working through is significantly different in that it is framed as an ongoing process. Given that *Girl, Interrupted* was published in 1993, and reflects on Kaysen’s institution in 1967-68, there is a longer period of time between the events about which she writes and the publication of her memoir, meaning that the narrative inevitably feels more closed off and finished. Whilst *My Body is a Book of Rules* is still a retrospective memoir, the events are more recent, and the continuing labour to actualise them is an integral part of the text. In *Lying*, Slater invites the reader on a journey; however, it is a journey that she has already been on and that we are encouraged to take only now that she has signposted it.

Whilst Slater invites us to hold her hand, she is also careful to keep us at arm's length. In contrast, the aesthetic of Washuta's memoir permits the reader to accompany her on that journey and to see her some of her workings out and her struggles. *My Body is a Book of Rules* therefore challenges Gilmore's argument that, as a consequence of neoliberalism, memoir has been emptied of its political capacity and formal potential. An exception to the rule, nevertheless Washuta's memoir demonstrates that life writing can still be a platform of experimentation and provocation.

In this chapter I responded to Nicki's call for a feminist methodology of reading that attends to both biomedical and social aspects of mental illness, and recognises the enmeshment of trauma and distress. I have demonstrated how a feminist engagement with psychiatric disability is able to negotiate the complexity and multiplicity of experiences of mental illness, and their expression in, and impact upon, literary narratives. Working within such a framework has enabled me to analyse the aesthetic similarities between Kaysen, Slater, and Washuta's memoirs, whilst paying attention to the significant differences of their contexts, their attitudes towards diagnosis, and their narration of trauma. It is also a mode of criticism that is sensitive to the ethical implications of scholarly writing about sexual violence, mental health, racism, and their interconnections. I have endeavoured to ensure that my mode of critical analysis has remained responsible and sensitive throughout, pointing to how the texts engage with issues of reliability, credibility, and traumatic memory, without undermining any of the writers' authority, or becoming merely descriptive. Situating myself at the intersections of feminisms, psychiatry, and disability, was fundamental to my being able to be an adequate witness to these women's testimony whilst maintaining a critical voice.

In the next chapter, I will explore texts that demonstrate a similar self-consciousness about their narrative construction of mental illness. This awareness – showcased in meta-narratives of the text's aesthetics and moments of tension in which the processes of the text's production create tears in its surface – stems from the ethical and practical difficulties of collaboration and co-production. As we shall see, multiple narrators, and, or writers further complicate the telling of stories of mental illness, and the power relations between these multiple tellers again results in discussions about legitimacy and authority, and how best to construct and convey them in narrative.

Chapter 2 Relational Lives, Collaborative Narratives: examining co-production

In an article entitled 'Illness and Autobiographical Work: Dialogue as Narrative and Destabilisation,' Arthur Frank asks a crucial question: 'What […] is a polyphonic illness autobiography, and what is the effect of such a performance?'[1] Asserting that the majority of illness narratives 'are written from the perspective of a single consciousness that filters and organizes events' and, having repeatedly suggested elsewhere in his research that 'the therapeutic need for autobiographical work is to create a performance of which such a unitary, organizing, masterful consciousness can be the effect', Frank realizes that these, in fact, reinforce the image of the ill person storying in isolation.[2] In this article, by way of contrast, he makes a turn from the monological - characterized as 'unitary, centered, having the last word' - to the *dialogical,* in the Bakhtinian sense of the term,[3] in order to explore the impact of multiplicity on the illness narrative. To do so, Frank makes the distinction between moments of *disruption* and *destabilisation. Disruption* occurs in the content of the narrative when the author-as-patient is upset by someone's malice or incompetence, for example Kay Redfield Jamison being told that she should not have children because manic-depression is hereditary, but nevertheless the author-as narrator takes ownership of the episode and smoothly incorporates it into their narrative. In contrast, *destabilisation* overflows the container of the story and impacts upon the structure of the narrative itself. Disruption is therefore primary, and destabilisation secondary: it is the result of not being able to assimilate the episode of disruption. It is worth noting, in addition, that destabilisation can be done intentionally. Using examples of physician's memoirs, a spiritual autobiography, and a website, Frank works

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[1] Arthur Frank, 'Illness and Autobiographical Work: Dialogue as Narrative and Destabilization,' *Qualitative Sociology*, 23.1 (2000), 135-156 (139).

[2] Ibid., p.138.

[3] Mikhail Bakhtin, *Problems of Dostoevsky's Poetics,* trans by Carl Emerson (Manchester: Manchester University Press, 1984).

through the dynamics of texts which actively invite the 'dialogical condition of polyphony' and are frequently destabilized accordingly.[4]

The article marks a welcome break from the typical direction of Frank's work on illness narratives. His awareness of the polyphonic nature of such narratives is more nuanced than his work in *The Wounded Storyteller* (as discussed in the introduction). His in-depth analyses of each text productively think through the consequences of the relationships between the subject and narrator-author, and the ways in which the narrator uses moments of destabilisation as a tool by which to build self-conscious moments of reflection into the text. However, as promising as Frank's framework is, his thesis falls disappointingly short of answering any of his own questions: 'my thesis is that the polyphonic narrative represents an assertion of identity and a way of doing autobiographical work for which ethical claims can be made'.[5] Surely this is true of any self-narrative? If the autobiographical act is performative, simultaneously constituting and writing the self, any piece of life writing, in whatever format, is an assertion of identity for which "ethical claims" can be made. Furthermore, when stating that he is focusing on narratives characterized by polyphony, Frank writes 'I seek not to prove that ill and disabled people in general think about themselves a certain way, but rather that such thinking exists as a possibility'; again this, in its provisionality, limits the scope of work that could have been developed more.[6] Finally, Frank's conclusion is problematic. He concludes that 'autobiographical work is about seeking wholeness' and that 'the premise of the dialogical perspective is that existential wholeness is inherently constituted in relationships with others'.[7] Whilst his definition of wholeness as 'the ongoing communication between simultaneous differences' is a neat one, I dislike the move Frank makes in concluding his article

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[4] 'Illness and Autobiographical Work', p. 140.

[5] Ibid., p. 139.

[6] Ibid., p. 140.

[7] Ibid., p. 153.

in terms of wholeness and brokenness, which over-simplify and damagingly encourage the concept and necessity of "fixing."

I wish to take up Frank's question about the nature of the polyphonic illness narrative and its effects, and complicate it by applying it to narratives that have been coproduced. Whilst many of texts in the previous chapter could be said to invite destabilization in the crafted, controlled sense of the term, and repeatedly played with dialogisim and polyphony – from Kaysen's photocopies to Slater's intertextuality to Washuta's footnotes – this chapter explores the tensions, gains and losses brought by co-production to life writing about mental illness. I am defining co-production as two or more people significantly involved in the production of the auto/biographical text, and I have chosen 'co-production' instead of 'co-authored' as the latter implies equal levels of agency that are not always present with life writing about mental illness. Furthermore, a co-producer is not always accredited as an author on the spine of the text, but has nevertheless been integral to its process and shape of the end product. I have also avoided 'co-construction' as the term belongs to ethnography and sociological enquiry and, whilst I want to draw attention to the similarities between autoethnography and memoir, I wish to distinguish the literary from the sociological. Co-production has other connotations in the context of mental health in which it refers to the active and ongoing involvement of patients and the public in research, policy, and care, and it is worth emphasising that whilst I am frequently critical of the workings of co-production in the texts in this chapter, I think that this use of the concept is integral to the provision of quality mental health care.[8]

As I have repeatedly demonstrated, ethics are inseparable from life writing, particularly in the context of mental illness, and this is all the more true of narratives that have

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[8] See, for example, Michael Clark, 'Co-production in mental health care,' *Mental Health Review Journal*, 20.4 (2015), 213 – 219; Steve Gillard et al, '"Staying native": co-production in mental health services research,' *International Journal of Public Sector Management*, 23.6 (2010), 567-577; and Steve Gillard et al, 'Patient and public involvement in the co-production of knowledge reflection on the analysis of qualitative data in a mental health study,' *Qualitative Health Research*, 22.8 (2012), 1126-1137.

been co-produced. G. Thomas Couser has written about the ethical implications of collaborative life writing, from ghost celebrity autobiographies to ethnography. He emphasises the ways in which the relationship between collaborative partners is marked by an imbalance due to difference in ‘culture, gender, class, age, or (in the case of narratives of illness or disability) somatic, intellectual, or emotional condition that renders them vulnerable to exploitation’.[9] Further ethical difficulties within the collaborative relationship are caused by the discrepancy between the roles of the two parties: generally, ‘one member supplies the “life” while the other supplies the “writing”’.[10] In the clinical/academic context of joint publishing first person accounts of mental illness, the stakeholders in this labour division are referred to as ‘content experts’ and ‘process experts’.[11] The collaborative relationship is therefore laden with responsibilities for the biographer (or process expert), especially when their subject is vulnerable. Taking Couser’s discussion into account and applying it to the context of mental illness and the frameworks of (counter)diagnostic readings that I have established, the biographer has a moral obligation to balance their desire, and need, for clarity, coherence, and explanation with an awareness of how the process and finished text will impact upon the subject, and recognise times when it might be necessary for them to protect themselves by evading their biographer, and, subsequently, reader.

The issues discussed in the previous chapter - counter-diagnosis, indirection, and claims to truthfulness – are all present in the texts used in this chapter, but complicated to yet another degree by the addition of another person in the process of creating the text. Life writing, even when singularly produced, is always about relationships: given that no-one lives

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[9] G. Thomas Couser, *Vulnerable Subjects: Ethics and Life Writing* (New York: Cornell University Press, 2004), p. 37.

[10] Ibid., p. 36.

[11] Abraham Rudnick, Tzviel Rofè, Daliah Virtzberg-Rofè, and Paolo Scotti, ‘Supported Reporting of First Person Accounts: Assisting People Who Have Mental Health Challenges in Writing and Publishing Reports About Their Lives,’ *Schizophrenia Bulletin*, 37.5 (2011), 978-81.

in isolation, no-one can tell their story without implicating others, hence Eakin's second rule of life writing discussed in my introduction, respecting the right to another's privacy. Relationships are even more integral to life writing that has been co-produced, not just in their content, but in their process of construction. Collaborative writing is not the same as co-operative writing: the subject and writer's motivations frequently come into conflict with each other, making the continuation of the text fraught, if not impossible. The ethical considerations inherent in writing a life become even more entangled when that life is not your own, or when you are appropriating stories from others' lives in order to tell your own self-narrative. This is, again, even further complicated when the dynamic of the collaborative partnership is governed by a clinical relationship or familial ties. Put simply, everything becomes more complex with co-production.

The focus of chapter one was on demonstrating how counter-diagnostic texts – those drawing on postmodern techniques in order to exceed typologies of illness narratives and disrupt reading experiences – highlight the need to develop more critically sophisticated modes of engaging with transgression, ambiguity, uncertainty, and contradiction. In doing so I argued that the purposeful aesthetic confusion characteristic of counter-diagnostic illness narratives renders them more productive in their assertions of difference, and more revealing in their depiction of the lived experience of mental illness. How, then, does this play out in the context of co-production? One might, somewhat naively, expect that co-production leads to a memoir which provides a "fuller" depiction of mental illness – on the grounds that the "inside" and "outside" of the experiences are present and so a "more rounded" text emerges; indeed this often forms the basis of reviews of such narratives, for example Alexander Linklater's review of *Henry's Demons* by Patrick and Henry Cockburn (discussed later in this chapter) in *The Observer* described the text thus: 'this is truly an account of living with schizophrenia from the outside and the inside'.[12] Contrastingly, one might hypothesise that the extra layer of

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[12] Alexander Linklater, 'Henry's Demons: Living with Schizophrenia, a Father and Son's Story by Patrick and Henry Cockburn – review,' *Observer*, 20 February 2011,

complexity created by the additional writer/narrator would exacerbate the aforementioned aesthetic confusion. Is it the case that multitudinal sources and their inherent convolution result in texts apposite to the portrayal of mental illness, the textual entanglements reflecting the disorientating nature and elusive origins of trauma, addiction, depression, or schizophrenia? This chapter argues once more for more nuanced reading practices when engaging with narratives of mental illness. The additional writer/narrator of these texts emphasises the issues already discussed in this thesis: indirection, reliability, credibility, and authority. However, rather than being illustrated through manipulation of literary techniques, they are presented as the inevitable consequence of the addition of another person in the processes of narrative construction and telling. Of course, these are not mutually exclusive, and as we will see some writers capitalise upon the additional writer/narrator through experimentation with form.

This chapter, therefore, is about *relationality* in mental illness and life writing. It explores the ways in which narrated encounters of mental illness are co-produced and the impact of this collaborative (or not so collaborative) process upon the presentation of the voice of the person with mental illness and their lived experience. It will argue that texts that draw attention to, worry over, and struggle with the complexities of the processes and tensions inherent to collaborative relationships are more revealing, than texts that negate and paper over the messy processes of their production. It will also call attention to the interactive nature of these texts, showcasing the ways in which life writing that relies on dialogue in constructing their narrative also call for the reader to enter into conversation with the text. This will be contrasted with memoirs that, whilst jointly told, narrate their stories side by side with little, if any, conversation between the accounts. These investigations will be grounded in the analysis of texts that have been co-produced to varying degrees: *Welcome to my Country* (1996) by Lauren Slater, *Stuart: A Life Backwards* (2005) by Alexander Masters, *Divided Minds*

<https://www.theguardian.com/books/2011/feb/20/henrys-demons-patrick-cockburn-review> [accessed 2/5/2019].

(2005) by Carolyn Spiro and Pamela Spiro Wagner, and *Henry's Demons: Living with Schizophrenia, A Father and Son's Journey out of Madness* (2011) by Patrick and Henry Cockburn.

Slater's second memoir, *Welcome to my Country,* is a compilation of tales, each centred on the relationship between herself, in her role as clinical psychologist, and a patient. As with Oliver Sacks' *The Man who Mistook his Wife for a Hat* (1985) and *An Anthropologist on Mars* (1995), these episodes blur the boundaries between short story, tale, and case study. Whilst each episode focuses on the experiences of a patient - in some cases a specific person and in others a composite entity created from numerous impressions and experiences - Slater argues that the text is a memoir on the basis that so much of her exploration of self emerges through the connections with another in the therapeutic encounter:

> These, then, are not just stories of my patients; they are stories as well of myself, of interactions and conflicts, of the way one psychologist watches her past meet her present, coming to see herself in the complicated lattice of her patients' lives.[13]

The result is a palimpsest of illness narratives that interweave to blur the boundaries between patient and practitioner, memoir and biography. *Stuart: A Life Backwards* is an auto/biography: it is written and narrated by Alexander Masters and depicts the life of Stuart Shorter, who has a diagnosis of borderline personality disorder alongside multiple addiction issues, as well as muscular dystrophy and a history of childhood sexual abuse. Set in Cambridge, UK, the text follows the development of the unlikely friendship between Alexander, physics graduate, writer, social campaigner, and Stuart, 'thief, hostage taker, psycho and sociopathic street raconteur,'[14] as they campaign for the release of Ruth Wyner and John Brock from prison following the pair's conviction for (unknowingly) allowing drug deals to take place on the premises of their homeless shelter. The text also illustrates many of the issues faced by homeless people through telling Stuart's story from his childhood to his

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[13] Lauren Slater, *Welcome to my Country*, (London: Penguin, 1997), p. xii.

[14] Alexander Masters, *Stuart: A Life Backwards*, (London: Fourth Estate, 2005), p. 6.

death, but in a non-linear order. *Divided Minds* is co-produced by identical twins Carolyn, a practicing psychiatrist, and Pamela, a poet who has lived experience of schizophrenia. The text interchanges between the two siblings, with their narratives separated by their names as subheadings. Similarly, *Henry's Demons* is co-produced by father and son, Patrick and Henry, and again, the text interchanges between chapters written by each party under their own name. Patrick, notable war correspondent, turns his journalistic prose to describing the impact of his son's schizophrenia upon his family and work. Henry, in contrast, writes about his "schizophrenia" as a spiritual awakening rather than in pathological terms.

Each of these texts provides a different way into a discussion on co-production, mental health, and life writing, and a means of answering Frank's seminal question, with which I started. In my selection there is one memoir, *Welcome to my Country*, that nods to co-production, but is in fact, to borrow from Frank, written from the perspective of a 'single consciousness which filters and organizes,'[15] one, *Stuart: A Life Backwards*, which is more of a biography than memoir, and two, *Divided Minds* and *Henry's Demons*, which are interchangeably co-written, although in the former the two voices sound suspiciously alike. Standing back from the texts, there seems to be an obvious set of pairings that lends itself to the structuring of this chapter: *Welcome to My Country* and *Divided Minds* both have a narrator who is a trained psychologist or psychiatrist respectively, providing a clinical medical lens through which to read the two together; in contrast *Stuart: A Life Backwards* and *Henry's Demons* rely on familial and friendship ties; *Divided Minds,* of course, acts as a bridge between the professional and familial, with Carolyn's dual role as psychiatrist and twin.

However, there is a more critically productive path through these texts I have chosen for this chapter, and that is to move from those which focus on the process of their production, self-consciously narrating the "story of the story," – *Welcome to my Country* and *Stuart: A Life Backwards* - to then contrast with those that negate this process and assume a

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[15] 'Illness and Autobiographical Work', p. 36.

naturalistic approach to their material – *Henry's Demons* and *Divided Minds*. The latter is the more difficult to critically assess because, as literary scholars, we are trained to handle aesthetic complexity and are at ease, relatively speaking, with postmodernism and its tricks. Verisimilitude is, ironically, harder to unravel, especially when the subject matter is so ethically loaded. Putting all of these texts in conversation, however, enables me to analyse the implications of professional medical ethics alongside those dictated by autobiography studies, as well as exploring the impact of melodrama and sentimentality in relation to disability studies. Continuing from the previous chapter, I will examine how the texts present different ways of telling indirectly in the collapsing of distinctions between mental illness, disability, and trauma. This chapter is less about the presentation of the lived experience of mental illness, and more about how the voice of the patient, and their collaborator, is characterized. It will parse moments of reciprocity, mutuality, identification, and separation between the co-producers, as well as between narrators and reader, with a view to furthering my exploration of encounters of mental illness and displaying the sophistication with which co-production functions as a narrative device.

Co-production in the therapeutic encounter: ethical considerations

I begin with an example of co-production in action as an exemplar of the processes I am describing. The third tale of *Welcome to my Country,* "Some kind of cleansing," is the story of Slater's relationship with Joseph, a patient with chronic schizophrenia. Joseph had previously lived in the North of Boston in an Italian immigrant family. He was the first in that family to go to university, accepted into Princeton to study literature and social psychology. Whilst there, he became paranoid and manic, and, when he returned home for the Christmas holidays, exposed himself in front of his relations. Having failed his first semester, he never returned to university, but remained home where his speech deteriorated, and he increasingly experienced delusions and hallucinations. After Joseph's mother, his only carer, died, his siblings placed him in the residential unit at which Slater worked. Displaying the disorganisation and overinclusion characteristic of schizophrenia, Joseph’s relationship with language, meaning, and communication is fraught. Whilst Joseph writes compulsively – covering tissues, paper, serviettes, walls, and other people – what he writes seemingly lacks any coherence. Rather than his writing acting ‘as a series of strings’ between writer and reader, ‘drawing [them] close in communion, with Joseph words were a wall’ (p. 74). As a consequence of his struggle to organise verbal language, Slater fails to connect with him ‘in a way that felt satisfying’ (p. 74), and is unable to engage him in therapy accordingly.

Joseph’s inability to separate and categorize language in order to create coherent meaning is particularly frustrating and terrifying for him as someone who once won scholarships on the grounds of his literary prowess. Indeed, at one point he exclaims, ‘I wish with a dowager’s meaning that I could separate it, that I could read and write again’ (p. 71). When Slater asks him ‘what is it like to be so confused about words?’ he replies ‘”it is like … being trapped inside the dragon”’ (p. 75). This, Slater states, is the first cogent thing he had ever said to her. This episode provides momentary connection between Joseph and Slater, prompting Joseph to share with her his “special book” which is covered in writing, with lists and attempted translations coating the pages. When asked what his words mean, Joseph, downcast, answers that he cannot explain, but flips to the back page, where ‘surrounded with drawings of dove-shaped wings,’ he had written:

‘OH THAT I COULD GO TO THE SKY
WHERE I MIGHT FIND A CLEAR KNOWING’ (p. 77).

The beauty and clarity of this longing statement are exacerbated by its place amongst Joseph’s incoherent scribblings.

Joseph’s sessions with Slater take on a formulaic tendency: they consist of Joseph sitting at his desk compulsively writing with Slater standing next to him unable to engage with him or interpret his writing. Finally, frustrated with her own sense of powerlessness and destabilisation of her supposed position as “expert,” in one session Slater takes the pencil from him and writes her way onto his page. Joseph had written that church ‘is where peropper people go. Worms sleep inside of me, all clouds and test tubes,’ and Slater adds underneath that she had once gone to church as a child and remembered seeing the crucifix on the wall. Slater’s act of writing herself into Joseph’s stream of consciousness stuns him. Whilst it does not ‘begin a correspondence,’ (p. 90) as Slater had hoped, it does prompt Joseph to literally reach out and touch her nose and eyebrows. In doing so he seems to recognise her, and to recognise himself in her: ‘he was studying me, studying my shape, like a man remembering something, finding his former self’ (p. 92). A moment of connection and reciprocity has been enabled by literally, and literarily, crossing into each other’s space, both physical and textual.

After this episode there is a hiatus in Joseph’s compulsive writing during which he refuses to eat and is more unkempt than ever. This lasts until he announces to the mental health team that he wants to return to school. They help him enrol at a local community college on his chosen courses, social psychology and creative writing. Refusing to let the team disclose his mental health status to the college, and consequently not receiving adequate support accompanying his studies, Joseph starts failing. However, Slater recognises ‘glimmers of coherence’ and ‘half-uttered themes that bled away into chaos,’ (p. 99) when reading his story submissions. It is after this that she has the idea of acting as a mental ‘cilia’ for Joseph. Given that Joseph’s barrier to coherence is his over-inclusion, Slater wonders ‘what would happen, […] if [she] acted as Joseph’s prosthetic filter – a brain extension – clearing away from his sentences the verbal spasms and dust, the intrusions, that dirtied an intact meaning? Would an intact meaning then emerge?’ (p. 102). It is in this way that Slater becomes the co-producer of Joseph’s writing, instigating as she does so a particular version of the collaborative relationships that form the basis of this chapter’s analyses.

With the analogy of cilia in mind, Slater changes her perspective towards Joseph’s writing: rather than reducing it to the status of ‘crazy gibberish’ (p. 103), she assumes the presence of a foundational meaning that had been buried by his over-inclusion. Consequently, she attempts to act as a screen in order to tease out sense. The following passage demonstrates this in action; the words in parenthesis are those originally written by Joseph that Slater disqualifies: '"Going back to school is (a keyboard to the excellence) exciting and I want to walk down the paths to the (black flag beating) backboard."' Slater suggests that the sentence could be further edited to read '"Going back to school is exciting. I want to walk to the blackboard"' (p. 103). Whilst the writing gains coherence as a result of Slater's editing, it loses its literary quality. Brendan Stone, whose work I referred to in my introduction, argues that the imposition of linearity and resolution on the experience of mental illness in order to make it into a contained and accessible narrative, renders the narration of the experience inauthentic.[16] He also proposes that, in the telling of their story, the patient has to step outside of the language sanctioned by medical discourse and turn towards a 'poetic, metaphorical,' indirect, and non-informative discourse in order to express their illness as valid, varied and individual.[17] However, in his articles, Stone implies a level of agency in the ability to make the choice to turn towards a different mode of language by which to express experience. Joseph, on the other hand, seemingly has no choice in how he expresses himself. Given the combination of his symptomatic inability to filter and compulsive need to write, how could Joseph be expected to decide which discourse to use? If it is only through Slater's editing that Joseph feels that he has communicated, what then? The metaphorical enables a more empowering communication for Stone, whereas Joseph, at least in how Slater presents him, only feels that he has communicated after his words have been subjected to her filtering.

In subsequent passages Slater acts not only as a filter, but in a more interventionist sense as a translator, relying on details of Joseph's life that she has learnt from his sister and his files to (re)construct, through deletions and additions, a narrative in his writing. This

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[16] Brendan Stone, 'Towards a Writing without Power: Notes on Narration of Madness', *Auto/Biography,* 14.1 (2004), 16-33.

[17] Brendan Stone, 'Why Fiction Matters to Madness', in *Narrative and Fiction: An Interdisciplinary Approach,* (Huddersfield: University of Huddersfield, 2008), pp. 71-77 (p. 75).

technique allows Slater to structure their therapy sessions differently. Instead of standing helplessly by, she gives Joseph a prompt, for example fear, and asks him to write. Later she filters the piece and, turning the passage into stanzas, creates a poem. Despite acknowledging the assumptions she makes about what is parenthetical and what central to the piece in undertaking this process, Slater, somewhat presumptuously, believes that she 'had allowed the spirit of the piece to emerge intact' (p. 106). The culmination of their processes, Joseph's writing and Slater's editing, is 'a beautiful poem, I thought, written, I thought, by Joseph' (p. 107). The use of commas here conveys a hesitancy as to the authorship of the piece; a difficulty at the heart of every collaborative relationship and co-produced text.

What is striking about the poem, later entitled 'Secret Illusion' by Joseph, is the way in which Slater describes his reaction to it: Joseph recognises the words as his: "Oh. My. Mine" (p. 107). Similarly with a longer prose passage, about being bathed by his mother as a child, that Slater 'cut and cleaned' (p. 107), Joseph appears to recognize himself in the writing: 'Hello, my mother. My words,"' (p. 111), and has a deeply emotional reaction to the piece. Nevertheless, Couser's question, 'whose property is a collaboratively produced life story?'[18] plagues Slater: 'Is this Joseph's real work? Can such a scrambled man take credit for a piece of prose so simplified, so smoothed? Who is *really* the author of this tale, that poem, Joseph or me?' (p. 108). Rather than one person providing the life, and the other the writing, here Joseph has provided both life and writing, and Slater, albeit disproportionately, the editing. A different editor would have resulted in different stories and emphases emerging from the partnership, yet that would be true of any collaborative relationship, and, as Slater states, 'this is the story I heard Joseph tell me; this is the story we shaped together. And no, I think he is not any less the author because his efforts merged with mine' (p. 109). Slater describes Joseph's emotional reactions and identification with the writings in part to use them as evidence of the power and benefits of co-production, and to justify his authorship.

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[18] *Vulnerable Subjects,* p. 47.

“Some Kind of Cleansing” is as much about the relationship that forms between Joseph and Slater through the act of co-production as it is the content of the co-produced works themselves. Collaborating in this way enables an intimacy to grow between patient and practitioner that surpasses their designated roles. It is through editing Joseph’s writing that Slater sees him, hears his voice, and recognises his pain (p. 107). Their ‘joint creation’ (p. 110) creates a ‘community of me and him together,’ (p. 110) through which Joseph displays physical intimacy, gently murmuring and touching Slater on the mouth ‘as a lover or a mother might’; it is significant that it is the mouth, the centre of voice, that he touches (p. 110). Beyond this, it is impossible to see Joseph’s view of their relationship because, as in his own work, his voice in the narrative as a whole is always filtered through Slater’s. Throughout the tale co-production is spoken of in terms of meeting, joining, and merging. However, at its end, Joseph’s emotional recognition of himself in their writing marks the point at which Slater realises the need to ‘separate again’ (p. 111). Knowing when to step back, Slater states, is the hardest part of a practitioner’s work. The way in which Slater describes this separation - ‘knowing there are times you must take a soft touch, fingers formed into a strainer, and bring them back to your own body’ (p. 111) – re-appropriates the image of the filter and enacts a re-crossing of space that book-ends the initial moment of textual and physical contact when she writes about going to church in his special book.

Reflecting upon the authorial integrity of Joseph’s writing prompts Slater to think about the version of co-production inherent in the structure of her own memoir. Joseph’s tale provides a concentrated example of the dynamics and complications of the collaborative relationship. Making the transition from the discussion of Joseph’s stories to her own, Slater acknowledges, ‘I can’t say that the pages you have before you here come from only me, for at every point these words […] are tangled in Joseph’s rhythms and history, as well as my own’ (p. 110). Slater’s memoir repeatedly questions the singularity of the subject-writer through emphasising their interconnections with others, even to the extent that she questions whether narratives can ever be ‘confidently claimed’ by an individual (p. 110). ‘Some Kind of Cleansing’ is an example of a therapeutic encounter of mental illness. It is the story of two people actively participating in the process of relationship, re-forming their selves in relation to each other, and doing so in the context of mental illness. Slater's identification with Joseph, her quest for reciprocity and interconnection with him, the consequential intimacy arising from their collaboration, her realisation of the need to subsequently re-separate, and the ethical dilemmas encountered in each of these processes are all contained examples of the dynamics to be investigated in the rest of this chapter. The analysis of this tale/case study, as a consequence, highlights the frames of this chapter – relationality, interdependence, and encounter – which can now be placed in their critical context.

Relationality and interdependence in critical contexts

Relationality carries with it a specific set of meanings within autobiography studies. It denotes a particular moment in the field at which second wave feminist critics characterised female authored memoirs, autogynographies, as distinct from those written by men on the basis that women's life writing was characterised by its relationality. In contrast to the phallogocentric, contained, singular 'I' which supposedly governed men's' autobiography, women, it was argued, wrote with particular awareness of their selves' dependence on, relationship with, or definition by an other.[19] Nancy K Miller and Paul Eakin both called for this conceptualization of relational selfhood in autobiography to be expanded beyond gender constraints.[20] Miller emphasises that 'in autobiography the relational is not optional' and continues, 'autobiography's story is about the web of entanglement in which we find ourselves'.[21] Back in 1999 Eakin stated that 'autobiography criticism has not yet fully addressed the extent to which

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[19] See Mary Mason, 'The Other Voice: Autobiographies of Women Writers', *Autobiography: Essays Theoretical and Critical,* (1980) 207-35.

[20] Nancy K Miller, 'Representing Others: Gender and the Subjects of Autobiography', *differences: A Journal of Feminist Cultural Studies,* 6.1 (1994), 1-28.

[21] Nancy K Miller 'The Entangled Self: Genre Bondage in the Age of Memoir', *PMLA*, 122.2 (2007), 537-48, (544).

the self is defined by – and lives in terms of – its relation to others'.[22] This chapter will demonstrate how, twenty years later, that is still the case. Eakin coined the phrase '*the relational life*' to describe 'the story of a relational model of identity [irrespective of gender], developed collaboratively with others'; his examples including Edmund Gosse's *Father and Son* (1907), Virginia Woolf's *A Sketch of the Past* (1939-40), Carol Kay Steedman's *Landscape for a Good Woman: A Story of Two Lives* (1986), and Phillip Roth's *Patrimony* (1991).[23] Looking back to the previous chapter, Eakin's sense of the term 'relational life' can be easily applied to *Lying*: the wellbeing of Slater's mother is inextricably linked to the state of her own mental health. Eakin argues that, because 'all identity is relational […] the definition of autobiography, and its history as well, must be stretched to reflect the kinds of self-writing in which relational identity is characteristically displayed'.[24] However, as with Frank's article at the start of this chapter, Eakin makes reference to the relational principally in order to emphasise the plurality of the singular first person of autobiography; again, the potential of exploring the dynamics of relationality in co-produced texts is missing.

Whilst in the 1980s it was feminist scholars destabilizing the myth of autonomous individualism, in the 1990s it was academics and activists within disability studies who took up this battle.[25] The concept of independence, and its relation to autonomy and selfhood, is especially loaded in the contexts of intellectual and physical disabilities for obvious reasons. In an article entitled 'Independence, Dependence, Interdependence: Some reflections on the subject and personal autonomy,' Solveig Magnus Reindal does away with modernist conceptualizations of the subject and personal authority inherited from Kant, Mill, and Hume, criticising their essentialism, and the ways in which they situate interdependence as

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[22] Paul John Eakin, *How Our Lives Become Stories: Making Selves* (London: Cornell University Press, 1999), p. 43.

[23] Ibid., p. 57.

[24] Ibid., p. 43.

[25] Today's debates emerge from the intersections of queer studies, feminisms, race, and disability studies. See Alison Kafer, *Feminist, Queer, Crip* (Indianapolis: Indiana University Press, 2013) and Ellen Samuels, *Fantasies of Identification: Disability, Gender, Race* (London: New York University Press, 2014).

'preliminary and occasional'.[26] Instead, Reindal demonstrates how the subject, being both embodied and embedded, must be viewed as relational, and consequently argues that *interdependence* is the foundational state of the human condition. Interpreting the human condition as one of interdependency and vulnerability, Reindal argues, enables us to move on from the traditional false dichotomy of independence and dependence, and to reconfigure independence as 'partnership' based on mutual responsibility. This leads Reindal to argue that interdependence, in terms of 'independence is partnership,' is essential for developing the social model of disability. In the context of this chapter, Reindal's work is useful in illustrating the foundational nature of relationality, and consequently interdependence. Where Eakin, in autobiography studies, demonstrates that *life* is relational, Reindal, using disability theory, proves that the *subject*, disabled or not, is relational.

Given the primacy of the relational, and its dependence on mutual responsibility, it is unsurprising that it has been used as a model of ethics in therapeutic and ethnographic contexts. In counselling and psychotherapy relational ethics is construed as 'a co-constructed ethical and moral encounter' between client and practitioner that 'both influences and in turn is influenced by the complex multidimensional context in which the relationship occurs'.[27] Relational ethics here 'represents the complex medium through which decisions and interactions associated with the processes and progress of a relationship are mindfully and ethically engaged with'.[28] While this is a straightforward enough outline of the values inherent in the therapeutic encounter, it reminds us that the processes of relationship are foregrounded in the clinical setting; and this provides useful context when analysing encounter, relationality, and reciprocity in *Welcome to my Country.* Within the field of ethnography, Carolyn Ellis has explored the ethical implications of autoethnography and co-

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[26] Solveig Magnus Reindal, 'Independence, Dependence, Interdependence: Some reflections on the subject and personal autonomy,' *Disability & Society,* 14.3 (1999), 353-367 (353).

[27] *Relational Ethics: Narratives from Counselling and Psycotherapy*, ed. Lynne Gabriel & Roger Casemore (London: Routledge, 2009).

[28] Ibid., p. 1.

constructed autoethnography.[29] In an article entitled ‘Telling Secrets, Revealing Lives: relational Ethics in Research with Intimate Others,’ Ellis explores the varying ethical implications of becoming friends with research participants over the duration of an ethnographic project; writing about family members and friends who have died; writing about the experience of caring for her chronically ill mother; and collaboratively writing about bulimia and abortion. These scenarios throw up issues around the obligations of a researcher towards their participant, the right to privacy – both of the subject and those implicated in, or affected by the account – and the implications of not telling, or half telling, the content of the account to the subject in order to protect them. Having reflected on the power dynamics inherent in ethnography and in autoethnographies about those who have died, or are too ill to correct the writer’s account, Ellis moves onto two examples of co-constructed autoethnography that, because the researchers are also participants, she feels evade many of these ethical dilemmas. These include a co-constructed article about the embodiment of bulimia and an article written with her partner about their choice to terminate a pregnancy.[30]

The article about bulimia was collaboratively produced through interactive interviews in which each member acted as both researcher and participant. In this way they felt that they avoided, or at least reduced, the impact of some of the pitfalls of ethnography, for example explaining and gaining informed consent, ‘intruding into the lives of unsuspecting and vulnerable others, coping with participants who changed their minds about having their story told, revealing what should have remained private, doing emotional harm’.[31] However, I would argue that many of these issues remain salient and that being both researcher and participant

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[29] Carolyn Ellis, ‘Telling Secrets, Revealing Lives: Relational Ethics in Research with Intimate Others’, *Qualitative Inquiry*, 13.1 (2007), 3-29.

[30] Carolyn Ellis, Christine Kiesinger, and Lisa Tillman-Healy, ‘Interactive Interviewing: Talking about emotional experience,’ in *Reflexivity and Voice,* ed. by R. Hertz (Thousand Oaks, CA: Sage, 1997), pp. 119-49.
Carolyn Ellis and Arthur P. Bochner, ‘Telling and performing personal stories: The constraints of choice in abortion,’ in *Investigating subjectivity: Research on lived experience,* ed. by Carolyn Ellis and Michael Flaherty, (Newbury Park, CA: Sage, 1992), pp. 79-101.

[31] ‘Telling Secrets, Revealing Lives,’ p. 20.

can, in fact, put pressure on the subject as their double investment in the project may make them feel obliged to disclose more than they are comfortable with for the sake of furthering their research. Furthermore, the fact that one participant was a professor, interested in but with no personal experience of bulimia, and the other two were her PhD students, both of whom had experience of the eating disorder, creates a problematic power dynamic that, despite safeguarding methods put in place to protect each participant, cannot be ignored. That Ellis demonstrates awareness of the ethical complications of co-construction, yet still presents it as a solution to evading other ethical difficulties presented by ethnography, is troubling.

The memoirist and the (auto)ethnographer share many of the same ethical considerations. Autoethnography, Ellis describes, 'involves a back-and-forth movement between experiencing and examining a vulnerable self and observing and revealing the broader context of that experience'.[32] Memoir, particularly those focused on experiences of mental illnesses, does the same, but in a literary context of narrative and aesthetics. Lucy Burke, writing about intersubjectivity and relational models of identity in the context of Alzheimer's memoirs, asks 'what […] is at stake in telling the story of another's illness and in taking the history of this illness as part of one's own life narrative?'[33] Similarly Ellis' questions – 'what are our ethical responsibilities toward intimate others who are implicated in the stories we write about ourselves?'[34] and 'how do we honor our relational responsibilities yet present our lives in a complex and truthful way for readers?'[35] – present as much of a dilemma for memoirists and biographers as they do ethnographers. In answering her own questions, Ellis turns towards relational ethics for its prioritization of 'mutual respect, dignity, and connectedness' between co-producers.[36] However, as noted above, Ellis uses co-researched

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[32] Ibid., p. 14.

[33] Lucy Burke, 'Oneself as Another: Intersubjectivity and Ethics in Alzheimer's Illness Narratives', *Narrative Work: Issues, Investigations, & Interventions*, 4.2 (2014), 28-47 (30).

[34] 'Telling Secrets, Revealing Lives,' p. 5.

[35] Ibid., p. 14.

[36] Ibid,. p. 4.

and co-produced autoethnography as a way of circumnavigating many of the ethical issues of writing about others in ethnographic research. In contrast, my focus is on the additional ethical complexity arising from the process of co-production.

Auto/biographical disruptions in *Stuart: A Life Backwards*

Master's *Stuart: A Life Backwards* showcases the ethical, and potential aesthetic, complexities of co-production involving a vulnerable subject. This text is an auto/biography; a genre of life writing that 'focuses on the relation between the writer and a significant other'. [37] As such, as much of the narrative is dedicated to the development of Stuart and Alexander's relationship as it is to the events of Stuart's life. The text has yet another dimension of ethical complexity because Stuart dies before its publication. Masters reveals at the start of the text that Stuart stepped in front of a train and died. However, there is no further elaboration on the nature of his death until the epilogue. Instead, the narrative goes back in time to depict how Alexander met Stuart through his job at a homeless shelter and how their unlikely friendship developed as they campaigned together to release Wyner and Brock from prison. It was during this process that they decided to write a biography of Stuart's life. Alexander is a middle-class physics graduate, writer, and social campaigner, and has access to the according privileges. Stuart had muscular dystrophy, borderline personality disorder, and multiple addiction issues arising from prolonged alcohol and substances abuse. He had been repeatedly incarcerated, often homeless, frequently self-harmed, and made multiple suicide attempts, the last of which may have been successful. During childhood, he was also repeatedly raped and sexually assaulted by his brother Gavvy, babysitter, and teacher Keith Laverack. However, to establish a linear cause and effect relationship between his traumatic experiences of sexual abuse during childhood, his self-destructive and violent behaviour, and potential suicide, would be a gross

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[37] Couser, *Vulnerable Subjects*, p. ix.

over-simplification. Even to describe him by such a list is reductive. Given the entangled nature of such complex issues, how, we can ask of Masters' text, can one person narrate the other?

Auto/biographies exemplify Eakin's workings through of the relational life. Indeed, the interdependence of the two parties is reflected in the term. Delving deeper into the relational, Eakin coined the phrase "the story of the story" to denote the narrative that 'relates the genesis and execution of the collaborative enterprise that produces the first story'.[38] The "story of the story" structures the narrative, with the stress 'on the performance of the collaboration and therefore on the relation between the two individuals involved'.[39] Relational life is consequently reflected in narrative structure. Exploring such a dynamic in her book, *Mirror Talk,* Susana Egan also investigates auto/biography, defining 'mirror talk' as 'the encounter of two lives in which the biographer is also an autobiographer'.[40] She writes that, when both parties are involved in the preparation of the memoir, 'narration then takes the form of dialogue; it becomes interactive, and (auto)biographical identification becomes reciprocal, adaptive, corrective, affirmative'.[41] These frameworks clearly apply to *Stuart.* Whilst sold as biography, the story of the life of Stuart Shorter, auto/biography is a more accurate label as Alexander increasingly occupies Stuart's space through the metanarrative of their relationship and the preparation of the text. Egan's conceptualisation of narrative as dialogue which both affirms and contests is especially relevant in discussing Masters' atuo/biography. This is also Alexander's story, which is, put crudely, and in the terms through which the text is presented to the reader, the story of how he became friends with a chaotically unstable, but loveable rogue and learnt more about himself, his assumptions, and his privilege in the process.

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[38] Eakin, *How Our Lives Became Stories*, p. 59.
[39] Ibid.
[40] Susanna Egan, *Mirror Talk: Genres of Crisis in Contemporary Autobiography* (London, The University of North Carolina Press, 1999), p. 8.
[41] Ibid.

The framework of *Stuart* (its "story of the story") is characterized by Alexander, in his role as biographer, asking 'why?' and Stuart being unwilling, or unable to answer. There is a particularly acute version of the diagnostic urge between a biographer and their subject. This is necessary for the production of a biography: it is the biographer's job to act as detective; interviewing, unravelling, piecing together, and explaining. However, in the contexts of mental illness, disability, and trauma this mode of questioning and interpreting can quickly become fraught. This is even more so the case when there is such a discrepancy in the social privileges of the biographer and subject, as with Alexander and Stuart. This discrepancy causes frequent misunderstandings between the two:

> 'How long did you stay in the booby-trapped place?'
>
> 'You know, to be honest, that sort of question don't mean nothing to a person like me. That's what you're going to find difficult to understand. You grew up with order so you're going to want to explain things. Where, me, anything ordered was wrong. It weren't a part of my days. My life is so complicated it's hard for me to actually say what happened in them days let alone in what order.'[42]

Here Stuart succinctly explains how their different upbringings and experiences will prevent Alexander, not just from understanding the answers, but from knowing how to question. This difficulty is evident throughout the text as Alexander frequently despairs at Stuart's refusal to answer his questions whilst Stuart repeatedly becomes frustrated with Alexander's mode of questioning:

> '"But why put yourself on the streets?"
>
> "Alexander! Why, why why!"
>
> "But it's important, I want to understand"' (p. 56).

In reality, Alexander's persistent questioning betrays a lack of understanding at a more fundamental level: it is not just the answers, or lack thereof, that Alexander does not understand, but that his method of questioning is inappropriate. As Stuart repeatedly states, "*Stop asking why, Alexander. I don't know why. I was so off-key, half the time me mind had a head of its own*" (original italics, p. 57). Of course, it needs to be acknowledged that Masters

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[42] Alexander Masters, *Stuart: A Life Backwards* (London: Fourth Estate, 2006), p. 170.

makes a self-conscious decision in characterizing himself as such, a point to which I will return shortly.

Stuart's refusal to answer questions directly stems in part from an inability to do so due to the entangled nature of trauma, addiction, and abuse. As we have seen from Slater, sometimes indirection is the only way of telling and this chapter demonstrates the ways in which co-production offers an alternative method of telling indirectly. When speaking to Masters, Stuart's sister Karen, who was also abused by Gavvy, revealed that, '"[she's] never been able to talk graphically about it,"' (p.256), and that, having been referred to group therapy, she stopped after the third time because she '"couldn't handle it"' (p. 256). Stuart similarly refuses to talk graphically about his experiences. Narrated dialogue not only characterizes auto/biography, but is also one of the ways through which co-production tells indirectly.[43] This episode, Masters states, is 'the closest [he has] got to details,' (p. 265): driving in the countryside, he and Stuart stopped at a site where Laverack had been headmaster. Getting out of the car to look around, Stuart became confused by the building until he realised that it must have been knocked down and rebuilt as it was now only one story, and he had previously run away by tying bedsheets together to get out of a high window. After the police had brought him back from this attempt at running away 'it' happened:

> '"Happened?"
> "You know, in the office, after the police had gone."
> "What happened?" […]
> "I don't remember the face, only the movement"' (p. 266)

In this way Stuart simultaneously tells and refuses to tell the details of his abuse. On other occasions Stuart is unable to specify what happened to him due to being high on drugs at the time (p. 265); his prolonged dependence on various drugs has also had a long term impact upon his memory. Additionally, forgetfulness is something that Stuart actively strives after. His

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[43] The aesthetics of indirection and circumnavigation present in *Stuart* are also usefully informed by trauma theory. Dori Laub and Daniel Podell write that 'it is only through its indirect and dialogic nature that the art of trauma can come close to representing the emptiness at the core of trauma while still offering the survivor the possibility of repossession and restoration.' Dori Laub and Daniel Podell, 'Art and Trauma,' *International Journal of Psycho-Analysis*, 76.5 (October 1995), 991-1005 (993).

life, Masters writes, is one ‘based on forgetfulness’ in which ‘forgetting has become more important than remembering’ (p. 272). As Stuart says, most of his life has been spent ‘“trying to block [his] experiences at these schools out. Every day, every day, it’s like a big war what [he’s] always losing”’ (p. 265). Given that Stuart’s recollections of his experiences of abuse come to him in fragments, often talking, ‘about previous events as though he were studying a damaged photograph pixel by pixel,’ (p. 272) and his suspicion of anything ordered, it is appropriate that the narrative is non-linear and, as I will discuss shortly, multimodal.

As the title indicates, the text does not unfold chronologically. However, to say that the events are told ‘backwards’ is not entirely accurate. Instead *Stuart* oscillates and shuttles. This is appropriate for retelling the life of someone who has little sense of time passing: ‘some minutes was long, other minutes was short. I know that. Sometimes I was in the park, sometimes I wasn’t. Sometimes I was in a cell, sometimes I wasn’t’ (p. 170). Writing the auto/biography out of order was Stuart’s idea. Wanting a book ‘like what Tom Clancy writes,’ (p. 1) Stuart tells Masters to ‘do it the other way round. Make it more like a murder mystery. What murdered the boy I was? See? Write it backwards’ (p. 6). However, writing according to a murder mystery format encourages a detective fiction style of questioning that seeks out clues in order to solve the case, a mode of reading that is constantly resisted and undermined throughout the text.

Throughout his life Stuart found himself presented as a problem to be solved and explained, rather than a person to be listened to. His frustration with Alexander’s questions stems from a fear of being oversimplified, which is grounded in his experiences from various institutions. At HMP Grendon, for example, a therapeutic institution for mentally distressed prisoners, Stuart joined the group therapy session ‘and did his life story’ (p. 124). After the session had finished, ‘the therapist hurried after him in the prison corridor and said, ‘“Don’t you see? That explains it all. That’s why you’ve been offending”’ (p. 124). The tone of triumph betrays the naivety of the statement; as if Stuart’s ability to explicitly vocalise the factors that have contributed to his psychological distress would materially change anything. Performing his story is not curative. The therapist's preoccupation with explanation contributes to Stuart's alienation and he subsequently requests to be transferred to a regular prison. Stuart's experiences here speak to Peter Beresford and Anne Wilson's frustration with the ways in which health care professionals repeatedly received their stories of mental distress. In the introduction to the thesis I wrote how Beresford and Wilson described the experience of being on the 'receiving end of the diagnostic process,' during which they found that psychiatrists had 'enhanced interest in some aspects of our distress and the "playing down" of other aspects in order that it, or we, conform to a specific diagnostic category'.[44] In *Stuart*, it is not a psychiatrist trying to mould symptoms to a diagnostic label, but a biographer trying to shape experience into a narrative.

Despite the different disciplines – psychiatric versus literary – the difficulties arising from a diagnostic mode of reading are similar. In essence, they entail a failure to listen and respond to the subject in the appropriate way. Diagnoses are forms of explanation, and it is explanation, and its hierarchical nature, against which Stuart rebels:

> 'Yeah, you got the house, the education, the money, the fucking past what weren't full of abuse, you already got all that on me, and now you want me all tied up in explanations. That's what fucking people like you want, in'it? Because then it's all sorted, in'it? 'Stuart? Done him. Stuart? Yeah, explained him.' But you can't *I* haven't had it that simple. Why should *you* get to put reasons on it when I've fucking lived it and still can't?' (p. 213)

Explanations are, to Stuart, entities imposed on his life by middle-class educated people in order to contain, simplify, and solve him. They are restrictive and inadequate. They are also demonstrative of wider power relations: the ability to explain is a means of taking ownership of the experience in question. Whilst Stuart is unable to find the terms in which to express his trauma, he is angry at anyone else's attempt to do so and dissatisfied with the result. The

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[44] Anne Wilson and Peter Beresford, 'Madness, Distress, and Postmodernity: Putting the Record Straight' in *Disability/postmodernity: Embodying Disability Theory*, eds. Marian Corker and Tom Shakespeare (London: Continuum, 2002), pp. 143-57 (p. 146).

capacity to explain equates to a privilege and power to which Stuart has no access. Here, he projects and directs this anger at Alexander. This passage also brings us back to the ethical implications that Couser explores in *Vulnerable Subjects* concerning imbalances between parties in terms of class, physical and mental disability, and the disparity between the roles of "liver" and writer of the life. The relationship of each party to the events of the life, which become the material of the text, changes during the process of auto/biography: there is a constant renegotiation of who owns, and gets to express, the life. This is both a political and emotional renegotiation, as demonstrated in this dialogue:

> 'Alexander, it was *my* childhood,' Stuart spits, wrenching the study door open.
>
> '*Was,*' I yell back. 'It's mine now.' (pp. 212-13)

After this outburst, Masters writes, somewhat facetiously,

> In biography, most of the time, the real person is a nuisance. One wants them out of the way. If only they'd stop muddying the waters with inconsistencies, denials, forgetfulness and different interpretations of your language you could extract their essence and be off down the publisher's. (p. 213-4)

Whilst tongue in cheek, this statement points to many of the difficulties that have to be negotiated by the biographer. This is but one example of Masters' self-conscious awareness of the process of auto/biography and self-characterization as someone uncomfortably negotiating the ethical implications of writing another's life. It is through the inclusion of moments of destabilisation, accusation, conflict, and self-consciousness such as these that the text opposes a diagnostic mode of reading.

As with *Lying* and *Girl: Interrupted,* there is an aesthetic of counter-diagnosis in *Stuart.* However, here it does not stem from using a postmodern aesthetic to frame the complexities of narrating mental health, but through episodes in which Masters allows Stuart's voice to interrupt and critique the narrative. These usually occur when Stuart gives feedback on the draft manuscript of the biography, providing a literal engagement with the text. They demonstrate the degree of Stuart's involvement and editorial role in the production of the text we, as readers, receive. Beginning 'Stuart does not like the manuscript,' (p. 1), the book opens with such a passage. Stuart criticises Alexander for being too academic in his prose – providing definitions, excerpts from articles, and flow charts which, Stuart criticises, look ‘like an Airfix kit,’ (p. 6). These are all subsequently cut from the text. Later in the narrative Stuart accuses Alexander’s sentences of not making sense: ‘they begin on one thing and go to something totally different’ (p. 281). Alexander is offended, and Stuart ‘picks through the pages. “Look – there! That bit!” He taps his finger just under the chapter number triumphantly’ (Figure 3). Amused and frustrated, Alexander then explains what an epigraph is to Stuart. This moment of humour further reinforces the differences in education and privilege between the two. However, more importantly Master’s drawing of Stuart’s hand pointing to the page further reinforces Stuart’s presence and role in the drafting of the text.

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Figure 3: Stuart pointing to the manuscript, p. 281

A more serious example of Stuart’s input occurs when he gives Alexander his school reports. Masters narrates their content and his surprise at how good they are (pp. 199-200), before moving on to narrate the start of Stuart’s abuse by his older brother Gavvy. At the beginning of the next chapter, however, Stuart literally interrupts the narrative shouting ‘No!’ and grabbing the pages back from Alexander. Furious, he admonishes Alexander, ‘Don’t you never learn?’ (p. 211). In the previous pages Masters had selected passages of the reports – ‘excellent progress,’ ‘good work,’ ‘very creative,’ and ‘great understanding’ (p. 200) – to paint the picture of a ‘six-year-old goody two-shoes’ to contrast with the ‘man now loping across the city with two suicide scars around his neck’ (p. 199). Pointing to passages which describe him as ‘*Extremely disruptive … Very distractible* […] *unpleasant to his classmates and adults*,’ Stuart demands, ‘Why haven’t you put those fucking bits in?’ (p. 211) and accuses Alexander of not ‘*listening*’ (original emphasis). Stuart’s indignation stems from the fact that Alexander’s selection imposes linearity on his experiences: ‘“And now you’re going to fucking make me out in this book like it was all good and then loads of things went wrong”’ (p. 212). Alexander fails to understand the significance of his selection to Stuart: “So what? So there are one or two bad comments in those reports. […] That’s not interesting. When did you lose the good, that’s what I want to find out. When did you become fucking useless?”’ (p. 213). The disjuncture between Stuart as the person with lived experience and Alexander as biographer come to the fore here. As stated at the beginning of this chapter, the additional writer/narrator renders the issues intrinsic to narrating a self doubly complex.

As well as emphasising Stuart’s involvement in the text through episodes of conflict narrated in dialogue and by drawing Stuart literally engaging with the draft, Masters includes an example of his drawing and examples of his handwriting. In this way Stuart’s presence in asserted in the form of the auto/biography, as well as in its content. Discussing the dynamics and routines of prisons, Stuart diverges ‘“D’you know,” […] “I thought screws was called screws cos, with their silly caps and that, that’s what they look like”’ (p. 210). On the next page

Masters includes this image, with the caption 'Drawing by Stuart Shorter'. Again, including this multimodal element interjects a moment of humour, and as with above, emphasises his embodied presence – here even more so because Stuart has drawn the lines, rather than Masters drawing a cartoon of his hand. Elsewhere in the narrative, Masters includes excerpts from Stuart's diary.

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Figure 5: Stuart's drawing of a screw, p. 111

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Across three pages interspersed with such excerpts, Masters relays the changing of Stuart's mood and rhythms to contextualise the difference in his handwriting (pp. 159-61). Deteriorating handwriting and blanks in the diary mark difficult episodes, whereas legible writing, colour coded with highlighters indicate a period of stability. In the next chapter, on comics and mental illness, I will discuss in detail the importance of handwriting and the different characteristics of lines on the page, and their link to autobiography. For now, I simply want to include these images as examples of the multiple ways in which Masters self-consciously includes Stuart in the process and product of the text. Furthermore, the addition of these multimodal elements add another dimension to the dynamic of relationality that I have been unpacking in this chapter – both between contributors, but also, in these instances, between image and text.

In allowing Stuart to hold, to shape, to draw on, and to literally counter his narrative, Masters prevents the text from becoming diagnostic. Through the inclusion of moments of disharmony, anger and conflict Masters not only reinforces the authenticity of the narrative, but more importantly ensures that the text travels further than its narrator.[45] Within the narrative, Alexander enacts the role of a preliminary reader who receives and responds to Stuart's story. He performs a mode of reading which is inappropriate due to its diagnostic mode. The text then demonstrates this mode of reading to be inadequate and damaging, and corrects it. Consequently the auto/biography provides its reader with an example of failed reading, preventing them from replicating the diagnostic model in their own reception of the text. Throughout the auto/biography, in both narrated dialogue and self-reflective passages, Masters characterizes himself as bumbling, foolish, and frequently insensitive, and I suggest that the extent of this has been exacerbated for effect. In this way Masters as author critiques Alexander as narrator and character. What we have then, is Masters characterising himself as someone uncomfortably inhabiting the problematic space of relationality and attempting to

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[45] For more on the ways in which moments of instability make the text appear more spontaneous, authentic, and, ironically, stable, see Egan (pp. 8, 28).

recognise and negotiate the power dynamics and imbalances of an auto/biography about trauma, addiction, disability, and mental illness. In *Stuart* the story of the story is one of a biographer attempting to and failing to understand in constant loop. It is through this repeated process that he eventually grows closer to an understanding, which, in refraining from imagining itself as definitive, manifests as a more generous version of listening. Masters' throw away comment: 'I can't hope to justify or explain Stuart, I realise, nursing my headache: just staple him to the page' (p. 115) is actually the most significant realisation of the text in that it marks a change in emphasis from an attempt to find an *explanation* for Stuart's life, to a *representation* of it. Masters includes dialogue, moments of conflict, and multimodal elements in the text to create a narrative that not only conveys the events of the story, but also self-consciously reflects on the ethics of how to tell and how to engage with that story. This culminates in a text which refuses to give answers, but teaches its reader how to question and how to listen.

The text ends up being one that, like Stuart, refuses to provide answers, both because it cannot, and will not. Ironically, in one episode of conflict, Stuart had shouted at Masters to write a book without any answers:

> 'You fucking, wanky, middle-class cunt-fuck, Alexander, always saying, "What's the answer?" That's the difference, in'it? No answers! You want to know how I become what I am? Write a book what don't have no answers. But that won't make your fucking name, will it? Nah, see? Fuck off. Go find your fucking answers.' (p. 90)

Masters cannot answer the ultimate question: did Stuart commit suicide or was his death an accident? Stuart stepped in front of the 11.15 London to Kings Lynn train and died instantly. Whilst many presumed that his death had been suicide - the final act of tragedy in a life full of abuse and hurt - the coroner's report, detailed in the epilogue, listed reasons why this may not have been the case. In the end, the jury returned an open verdict: that it was neither suicide nor accident, 'but unfathomable' (p. 291). It is fitting that a story so resistant to direct answers, cannot provide the answer to the final question of Stuart's life: the nature of his death. Stuart could not have known the dark irony of his request that Masters write his life like a murder mystery.

Welcome to my Country: co-operation *or* appropriation?

In *Stuart,* Masters tells Stuart's life and the development of their relationship; inevitably telling some of his own story in the process. In *Welcome to my Country,* Slater actively appropriates her patients' tales, and the story of her relationship with them, as vehicles by which to reveal her own history of mental illness and abuse. Whilst Masters becomes implicated in the text of *Stuart,* the focus remains on Stuart, and the narrative of their relationship acts principally as another way of characterizing him – the text does not become about Alexander, and in no way does Masters use Stuart's story as a means by which to tell his own. In contrast, Slater, in her memoir, appropriates her patients' narratives as springboards from which to tell her own tale; indeed this is part of her justification for marketing the text as a memoir. So if the question with *Stuart* is 'how can one person narrate the other?' in *Welcome to my Country,* it is 'how can one person use another in order to narrate themselves?' There is a difference between the modes of co-production and indirection in each text: Stuart's voice comes to the reader indirectly as it is filtered through Masters' (although moments of instability such as I have discussed ironically make Stuart's voice feel more direct), whereas Slater uses her patient's narratives to tell her own story from a step removed – she tells almost through them, or certainly as a consequence of them.

Whilst Slater reflects on the dynamics of co-production in detail in 'Some Kind of Cleansing,' she does not depict the wider processes behind the writing of *Welcome to my Country* apart from to say that the patients' names, physical characteristics, and certain biographical details have been altered to protect their confidentiality and privacy, and that all patients agreed with the alterations made. Although Slater draws equivalences between the processes involved in producing Joseph's writing and her own, they are crucially different in that, whilst the patients are necessary for the structure of her memoir, they are not active participants in its writing. *Welcome to my Country,* then, provides a different version of what it means to jointly tell a story than that presented within ‘Some Kind of Cleansing’: one which is relational, but not co-produced. As stated, each chapter/tale/case-study in *Welcome to my Country* provides the story of Slater’s therapeutic relationship with a patient as they work through the patient’s experiences of mental illness and distress, and it is by examining the ‘vector points’ (xii) of her life and that of her patient that Slater reflects on and tells her own experiences of mental illness and abuse. This is how she weaves the ‘complicated lattice’ (xii) of her and her patients’ stories.

The second tale, ‘Striptease,’ centres on the relationship between Slater and a patient with an antisocial personality disorder, Peter. Peter is a misogynistic, sadomasochistic pornography and masturbation addict who domestically abuses his partner, Joanne, whilst claiming to love her. His father was an alcoholic who became sexually aroused through beating him. These childhood experiences, Slater tells us, have resulted in a deeply entrenched shame of the body and a hatred of, and need to control, its softness and weakness, which are characterized as particularly feminine. Peter’s disgust repeatedly makes Slater feel aware of and ashamed of her own body (pp. 41, 44, 49) and his need to control female flesh reminds her of her experiences of bulimia and anorexia as an adolescent and young adult. The shame of the body that Peter evokes in Slater remind her ‘with eerie clarity’ (p. 50) of her years of disordered eating – forcing herself to run miles in the midday heat, the ‘frail, dry odor, [of her body] like scorched grass,’ and her ‘limbs coated with hair’ (p. 44). Whilst it was impossible for Slater to like Peter, her memories made her empathise with him because she realises that she had ‘once striven for his same goals, to control the random, fleshy facets of female life, to eradicate the weak part of the self who hurts and bleeds and feeds’ (p. 44). Describing both herself and Peter as ‘victims of our culture’s fear of the feminine’ (p. 50), Slater realizes that, ironically, her experiences as a recovering anorexic put her in a better position to treat Peter due to her understanding of ‘the urge to whip and dominate, to discipline and even delete the female form’ (pp. 50-51).

Nonetheless, it is only after Joanne suddenly leaves him and Peter is in emotional pain that he and Slater connect. It is through slowly learning how to be vulnerable, and having the realisation that this vulnerability is not weakness, that Peter makes any progress in his therapy. Peter’s progress is paralleled with Slater’s memory of her recovery from her disordered eating. Like Peter, Slater recounts how she had to learn to become vulnerable, to let her guard down, and trust herself and her body (p.62). The paralleling of Peter and Slater’s fear of and shame of their bodies, and their respective gradual embracing of vulnerability serve to highlight the points of connection between them. Through listening to and relaying Peter’s pain, Slater is reminded of her own and finds a framework through which to express it. In the preface to the memoir, Slater writes that ‘there is no way to do the work of therapy, which is, when all is said and done, the work of relationship, without finding yourself in the patient, and the patient’s self in you.’ (xii); ‘Striptease’ illustrates this process in action with the least likely of patients.

The points of identification, reciprocity, and connection between Slater and her patients culminate in the final tale ‘Three Spheres.’ In this tale Slater takes on a new client, Linda Cogswell, who has borderline personality disorder. Slater has also previously received this diagnosis and, after being hospitalized for self-mutilation, Linda is sent to the same institution at which Slater had been a patient nearly a decade previously. Hearing the name of the institution triggers Slater’s memories of her own time as a patient there including ‘ivy on the brick, the shadow of a nurse, a needle, the way night looked as it fell beyond the bars…’ (p. 178). Having been assigned Linda’s case, Slater must return literally and metaphorically to the place of her own institutionalization. This prompts Slater to reflect upon ‘the discrepancy between this current image of me [successful psychologist] and the tangled past it sprang from’ (p. 181), enabling a departure in the narrative at which Slater is the most explicit about her past. Here, Slater reveals how she was admitted to Mount Vernon every other year between the ages of 14 and 24 for a duration up to several months until her '"recovery"' (p. 181) at 25. However, even today, Slater writes, as a 31 year old woman, 'with all of that supposedly behind [her], with chunks of time in which to construct and explain the problems that led [her] to lockup,' she cannot find the words by which to relate her experiences directly (p. 181). Instead, 'images come' (p. 181) and it is through these images that she tries to 'illuminate' (p. 181) part of her story. The images include sitting under the piano as a child watching the pain in her mother's face as she played; lying in bed whilst her mother murmurs a Hebrew prayer and imagining 'her hands exploring me, and a darkness sprouts inside my stomach' (p. 182); trying to find the roots of her pain, described as a plant, with a razor blade at the age of twelve; and weeping 'for the things inserted into me, the things plucked out of me' (p. 182). Slater was subsequently taken to hospital and then to a foster home in a repeated loop until her early twenties, during which time she also developed an eating disorder. In a memoir reliant upon the stories of others in order to reveal the self, these images provide yet another way of telling indirectly. In *Lying,* discussed in the previous chapter, Slater used epilepsy and Munchausen's as metaphors by which to tell her distress indirectly. In *Welcome to my Country,* written and published prior to *Lying,* Slater uses her patients' narratives as paths into a discussion of her own pain, and even at this late point in the memoir, when Slater is being most explicit about her experiences of mental illness, she continues to write through indirection – coming close to the pain, but refusing to verbalise the precise details of its cause. This is similar to the ways in which Stuart refuses to explicitly vocalise his experiences of abuse and how Masters shapes the text to enact this refusal. Both Stuart and Slater come close to the nature of their experiences, but refuse to tell them directly, and it is the various modes of indirection which make the respective texts so aesthetically innovative and challenging.

Returning to Mount Vernon to visit Linda marks the definitive point in the memoir at which patient meets practitioner: both Slater being introduced to her new patient, but more significantly, Slater as practitioner remembering, recognizing, and reconciling her experiences as patient. At Mount Vernon, she is consumed by paranoia that one of the staff members will recognize her and destroy her professional credibility, whilst simultaneously wanting to reveal herself in an act of defiance to the institution that thought that she would never recover. Returning to the ward prompts memories of her stay there and emphasises the interconnectedness between Slater and the current patients. Passing the room which she once occupied, Slater slows to see a blond woman lying in ‘what used to be [her] bed’ (p. 186). Thinking about the cells she must have left behind in the same mattress, Slater reflects on their physical and emotional interconnection: ‘As she sleeps, my name etches itself on her smooth flesh, and my old pain pours into her head’ (p. 186). Here, time and memory are fluid, boundaries are permeable, and pain is shared. Having automatically made her way to the patients’ bathroom, rather than the staff one, Slater has to cover her blunder to a nurse, claiming to have visited a patient on the ward before. In an internal monologue, Slater writes ‘How stupid of me. What’s she thinking? Can she guess? But in a way I *am* one of the patients, and she could be too’ (p. 195). Slater’s use of the present tense here highlights the continuing connection between her and the patients. Her experiences are not separate, bracketed off and contained in the past, as perhaps she would like, but present and shared.

Memories continue to surface throughout Slater’s visit to Mount Vernon. The conference room in which the meeting to discuss Linda’s case history takes place is the same room as where, when she was 14, Slater met with her mother and social worker for the last time and learnt that she was being put in a foster home. The narrative proceeds to cut between the contemporary meeting between psychiatric professionals discussing Linda, and Slater’s memories and images of her mother as she tries to retain her composure. After the conference, it is time for Slater to meet Linda. This moment, the initial meeting of patient and practitioner, is also framed as a meeting with the self. Seeing a ‘stooped’ woman who looks older than her age ‘with tired red ringlets,’ come down the hall, Slater extends a hand to greet ‘not only her, but myself’ (p. 197). Slater places the key to the interview room in the door and then stops and directs Linda to turn it. Keys, Slater has told us, are symbols of ‘freedom and power and finally separateness' (p. 197). Passing the key to Linda is a means of crossing the 'rift' (p. 189) between psychologist and patient – akin to writing on Joseph's book - as well as bestowing agency. Here Slater empowers not only her patient, but also her past self, trusting herself and her hybrid experiences. The interview room that they enter is one which Slater has been in over a hundred times as a patient, but this time, 'my patient and I sit down, look at each other. I see myself in her. I trust she sees herself in me. / This is where we begin' (p. 199). It is appropriate that these final words of the memoir emphasise relationality, mutuality, and reciprocity; the concepts which underpin the entire structure of the text. This ending is strikingly similar to the first edition of *Lying,* entitled *Spasm*: 'Lauren. My name is Lauren. And you are? Here, in this strange space is where we meet'.[46] Each ending focuses on an encounter, either between patient and practitioner, or writer and reader, and draws attention to the space between them and the exchange taking place. The similarities between the ways in which the encounter of patient and practitioner, writer and reader, are framed are vital: relationality, encounter, reciprocity, interconnection, and identification structure *Welcome to my Country* but also provide a model of its reception and reading.

The interconnections and reciprocity between patient and practitioner explored throughout *Welcome to my Country* mirror those between memoirist and reader. Slater writes that therapy is the work of relationship, that it transforms 'when it is the slow learning about connection and separation, the visceral study of painful lacunae and blue links' (xii), and that her job is not 'simply to listen,' but to accompany her patients as their 'co-worker, co-discoverer,' (p. 53). These dynamics of the therapy session are replicated in the reader-writer relationship upon which every memoir depends. In *But Enough About Me*, Miller writes how the 'writers of autobiography and readers of autobiography are codependent'.[47] This brings in a new element of relationality that has not yet been fully explored in this chapter: that which

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[46] Lauren Slater, *Spasm* (London: Meuthen, 2000), p. 223.

[47] Nancy K. Miller, *But Enough About Me: Why We Read Other People's Lives* (New York: Columbia University Press, 2002), p. 3.

exists through the text between reader and writer-narrator. Miller demonstrates how the relational mode depicted within life writing 'is also the model of relation that organizes the experience of reading autobiography itself'[48] and argues that this connective bond between writer and reader is founded in the ways in which the reader identifies, and disidentifies, with the memoirist. The identification with the writer's story prompts the reader's memory of their past experiences in what Miller dubs acts of collaborative remembering. Reading a memoir therefore becomes a process of 'interactive remembering' in which the text 'prompts the construction of memory itself'[49] and as such, 'other people's memories help give you back your life, reshape your story, restart the memory process'.[50] Miller's description of the writer-reader bond and collective memory clearly overlap with how Slater talks about the relationship between her and her patients, and the ways in which their stories prompt her to reflect on her own life. Miller's model of identification and disidentification are found within Slater's relationships with her patients; Slater's identifications with Peter, for example, bring up memories of her disordered eating, yet she also, crucially, disidentifies with him, and it is this oscillation between identification and disidentification, empathy and disgust, proximity and distance that characterizes their therapeutic relationship.

Slater's collaborative remembering through and with her patients in *Welcome to my Country* enacts the processes of reading memoir described by Miller. As she states, in treating her patients, 'memories [which she] thought were buried rise up' (p. 182). It is perhaps unsurprising then that Slater's alertness to the dynamics of interconnection, reciprocity, and mutuality at work in her relationships with her patients translate into an awareness of the relational bond between herself and the reader that is instigated by her memoir. In the preface Slater writes that she believes 'in a place somewhere in the air, where my self and your self might meet, merging in what we might learn to call, at least for a moment, love' (xiii).

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[48] Ibid., p. 2.
[49] Ibid., p. 7.
[50] Ibid., p. 25.

Later on she writes, ‘I watch as I press a series of separate keys on this computer and up through the gas plasma screen drifts a story for you. And for me. In this way we join’ (p. 66). In this way Slater continues to craft the text as a ‘strange space’[51] in which writer and reader meet, connect, and join; further enacting the writer-reader bond described by Miller. This direct address to the reader actively draws their attention to the relationship they are forming through their reading of the memoir. As such Slater demands that the reader be active, rather than passive, in their reception of the text.

Interaction is crucial to *Welcome to my Country* and *Stuart: A Life Backwards.* As we have seen, the ways in which Slater frames her encounters with her clients mimic as well as establish the ongoing encounter with her reader that is staged by the memoir. Using the second person pronoun, she directly addresses and calls her reader to join, merge, identify, and disidentify as she has done. The interactions between Stuart and Alexander in Masters’ auto/biography build the metanarrative, or “story of the story,” of the text. The informal interview-esque dialogues between them present a different version of interactive, collaborative memory. It is through responding, or refusing to respond, to Alexander’s questions that Stuart remembers and reinvents his past. The moments of destabilization, which prevent the text from becoming diagnostic, occur as a result of conflicts between Alexander and Stuart. These moments make the story and subjects feel more proximate to the reader, but also, as I have argued, model the ways in which the reader should and should not interact with the text. Slater and Masters may model their relationships differently, but the result is still to emphasise the role of interaction, and to invite their reader into the text. Frank, in the article discussed at the beginning of this chapter, argued that ‘the reader cannot learn about dialogue from these texts but must enter the dialogue of these texts; autobiographical work is not a spectator study but a relation’.[52] The reader must become an active participant in

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[51] *Spasm*, p. 223.

[52] Frank, ‘Illness and Autobiographical Work’, p. 147.

the conversations set up by the texts. Egan, with more nuance and depth than Frank, also foregrounds the role of interaction in *Mirror Talk* and deems it to be the characteristic feature of auto/biography. This interaction, she states, takes place between narrators/subjects, across genres, and between writers and readers.[53] Evidently Frank and Egan's theory applies to Slater and Masters' texts. However, what is striking moving forward is how the two "traditionally" co-produced texts, *Henry's Demons* and *Divided Minds*, neither display interaction between their narrators, nor demand active participation from their readers.

Family disagreements and conflicting voices in *Henry's Demons* and *Divided Minds*

Henry's Demons, perhaps deceptively, provides a more straightforward version of co-production. Co-produced by father and son, Patrick was adamant that 'it would definitely not be just a book with a joint byline, which in fact would be an account by [him] of Henry's ordeal, like the best-selling but ghostwritten memoirs of so many sportsmen, generals, and politicians' (xiv). Accordingly, the two authors write under separate chapters headed with their names. Henry wrote 5.5 of the 17 chapters. The others are written by Patrick, accompanied on one occasion by Jan Montefiore, Henry's mother. Patrick sets out the motivations for writing the memoir in the preface: he had felt that it might turn Henry's experiences into 'an asset' (xiii) on the basis that he and Henry, able to 'write from the *inside'* of mental illness, 'could serve a broader public purpose' (xiii) in demystifying schizophrenia. As such, the text fits with Anne Hunsaker Hawkins' model of the didactic pathography, which is written with 'the explicit wish to help others'.[54] Patrick also felt that writing about his experiences would make Henry recognise, or 'admit,' that he had a mental illness; he expected the memoir to act as a kind of therapeutic tool (p. 211).The subtitle, 'A father and son's journey out of madness,' establishes

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[53] Egan, *Mirror Talk*, p. 12.
In the next chapter on comics I will explore how the relationship between narrator/subject and reader shifts when visual representation comes into play, particularly regarding embodiment.

[54] Anne Hunsaker Hawkins, 'Pathography: patient narratives of illness', *Western Journal of Medicine*, 171.2 (1999), 127-129 (128).

the narrative templates of the journey and of a (supposed) recovery from the outset. Whilst Patrick is keen to emphasise that there have been frequent setbacks and relapses, that Henry's 'recovery is by no means complete,' (xiii), and that he could never have imagined how much of a protracted ordeal Henry's schizophrenia would turn out to be, nevertheless the text imposes a linear narrative from onset to partial recovery.

The memoir is about the impact of Henry's schizophrenia on the Cockburn family – Patrick (father), Jan (mother), Henry (son), and Alex (younger son). The family memoir is an inherently relational space – the relations are already built in as a consequence of the family unit – and this is exacerbated when the text comprises both parental and filial narratives. This is not, then, an auto/biography like *Stuart* in which one person narrates another, and inevitably themselves. Here father and son narrate themselves and each other, in addition to the illness; this provides a different version of collaborative telling from the examples discussed thus far. This is also the case of Pamela Spiro Wagner and Carolyn Spiro's 'dual memoir,' *Divided Minds.* Subtitled 'Twin Sisters and Their Journey Through Schizophrenia,' the text establishes itself in a similar fashion to *Henry's Demons*, with the joint journey narrative set up from the outset. Whilst it mentions some of the impact of Pamela's schizophrenia on the rest of the family, the text focuses on the impact of the illness on the relationship between the twins and their individual identities.

Claiming to display the 'inside' and 'outside' of mental illness might be a somewhat simplistic claim, but *Henry's Demons* does provide alternate perspectives of schizophrenia: Patrick places Henry's schizophrenia firmly within a medical model of mental illness whereas Henry does not recognise his experiences within biomedical or pathological frameworks. Instead, Henry interprets his visions and auditory hallucinations as 'an awakening, a spiritual awakening' (p. 31) and argues that he 'just see[s] the world differently from other people' (p. 43). Much of the text, from each perspective, is concerned with this fundamental disagreement of interpretation and classification. Patrick demonstrates how Henry's refusal to recognise his experiences as symptoms signifies his lack of ‘insight’ (p. 163) and the consequences this has at mental health tribunals, such as the repeated renewal of Henry’s sectioning. For Henry, the text provides him with a platform with which to counter this psychiatric designation and describe and validate his visions and voice-hearing.[55]

The text is characterized by the tension that arises from these irreconcilable subject positions and the implications this has for the family. The alternating voices of father and son result in a memoir that performs this disagreement (pathological versus spiritual). The impact of the parallel narratives is most striking when they describe the same episode, as is the case when relaying one of Henry’s many run away attempts. In Henry’s narrative this particular episode is given just one paragraph. Written in short, simple sentences, Henry describes sitting under a tree as it snowed for two days, becoming dehydrated, having a vision of his friend and the girl he fancied, and being found by a man who helped him. The prose is succinct and staccato and focused only on his actions – ‘I sat under a tree,’ ‘I was quite dehydrated,’ ‘I sat there wondering about my life,’ ‘I walked through the snow naked’ (p. 124). There is no space given to introspection or description, nor are there any details of his emotional state; instead it is written purely as a list of facts, with everything given equal weight -— from being close to death, to asking for orange juice, to rapping in the back of the ambulance.

The next chapter, written by Patrick and Jan, uses copies of Jan’s diaries from 2004 to recount the same episode from their perspectives. In their account, the episode was ‘more complicated, and considerably more dangerous’ (p. 132) than Henry’s recollections had depicted. They speak of being constantly ‘terrified’ (p. 131), and the ‘all-pervasive anxiety’, ‘emotional pummelling,’ (p. 132) and anger that accompanied the duration of Henry’s running away. Jan’s account details the phone calls from the missing persons officer and the police in their search for Henry; the difficulty of coping whilst carrying on with her work and Patrick

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[55] For a detailed linguistic analysis of how Henry describes these auditory verbal hallucinations, see Demjén, Zsófia, and Elena Semino, ‘Henry's voices: the representation of auditory verbal hallucinations in an autobiographical narrative’, *Medical humanities*, 41.1 (2015), 57-62.

being in Iraq; the fraught phone calls between them discussing the weather reports; the anger with the hospital for not having completed the blood tests which would have showed that Henry had not been taking his medication; the relief coupled with fury when he is found; and the guilt and terror realising that Henry had frostbite and would have died that night had he been found any later. What is particularly noteworthy is the absence of a joint reflection of the event. One might expect, after the individual accounts of the episode, a pause in the narrative in which both authors speak to the differences of their experiences and the repercussions of the episode on the family. Instead the memoir moves onto narrate the next in line of Henry's institutions.

In *Henry's Demons,* unlike *Stuart* and *Welcome to my Country,* there are no meta-reflections on the processes of textual production, no "story of the story." Instead, the different testimonies co-exist side by side with relatively little comment across them. It might be expected that *Henry's Demons* will perform a version of 'interactive remembering' – two people writing their responses to the same series of events. However, the accounts remain almost jarringly separate: this is a tale told side by side. After using Jan's diaries to describe the impact of Henry's running away on the family, Patrick comments that Henry 'never showed any regret or remorse for the misery he inflicted on us through his disappearances over about five years. He remained affectionate with us […] but he acted like what he did was taking place in a different world' (p. 132). Perhaps this accounts for why the two voices have to remain so staunchly separate: the two positions of seeing schizophrenia as illness and spiritual awakening cannot be reconciled, and a lack of awareness is characterised as part of Henry's experiences.

The distinctiveness of the different voices and accounts remains even at the end of the memoir. Patrick writes of Henry's progress how he is spending increasing time in step-down facilities and, recognising that it helps him manage his episodes of mental and emotional distress, is now compliant with his medication. Patrick also states that 'Henry increasingly recognises the existence of his illness and is more combative towards it' (p. 215). During a recent phone call, Henry told his dad that he had started to feel distressed and hear voices, but that he had 'dealt with them' (p. 215). Patrick responds:

> 'You defeated them?'
> 'Yes, I defeated them.' (p. 215)

Here Patrick imposes associations of battle and quest onto Henry's language, implying a sense of overcoming in doing so. However, this is then undermined by Henry's closing chapter. Henry contextualises his run away attempts by the poor conditions of the hospitals and the restlessness and despondency which accompanies institutionalisation. Rather than stating that he takes his medications because they help him, he is compliant because he 'doesn't think they do [him] any harm,' (p. 221) and he states that 'I am still not sure that I am mentally ill. It is certain that I do hear voices and that some people do not hear voices. I remember when I didn't' (p. 221). This undermines the resolution that Patrick's final chapter tries to establish. Rather than 'admitting' his illness, Henry ends his account reaffirming the spiritual nature and value of his experiences. The final line of the memoir is: 'there is a tree I sit under in the garden in Lewisham which speaks to me and gives me hope' (p. 222). Earlier on in the memoir, Henry had written about his interactions with trees, many of which had told him to go to London (p. 125). His ending, then, acts as a fulfilling of his voice-hearing which continues to give him hope. Both Patrick and Henry's accounts end on a positive note, looking hopefully to the future – Patrick's because Henry is seemingly recognising the pathological terms of his experiences, and Henry because he continues to draw strength from the spiritual dimension of his experiences.

This ending counters the otherwise paternalistic framing of the memoir. As we have seen, Patrick introduces the memoir stating how he had hoped that writing his experiences down would help Henry recognise and contextualise his experiences in a pathological framework. Alongside the obvious paternalism in the memoir – this is, after all, a father writing about and with his son – the framing exacerbates Patrick's authority. As Michael Flexer points out, Henry does not speak until chapter three, by which time his father has already established the details of his psychotic break, therefore 'setting a pattern whereby the supposedly more reliable narrator lays out a biographical and biochemical "objective" version, to be followed by a briefer phenomenological, subjective account by the "patient"'.[56] The disproportionate allocation of their chapters further emphasises this. Despite claiming to write the book in order to give Henry a voice of his own, and make that voice heard, Patrick acts as the interpreter and mediator of Henry's experiences; in one chapter even interrupting Henry's writing with asides that analyse his account. Patrick draws this authority from his position in the family; he establishes himself as the patriarch who has a special relationship with his son. This familial authority is not at play in *Stuart* or *Welcome to my Country* in which there are other factors governing the power distribution across relationships. I have already used Couser's *Vulnerable Subjects* to demonstrate the power dynamics at work between Stuart and Alexander created by their imbalance in social class, education, physical disability, and mental illness, and the power relations between Slater – trained clinical psychologist – and patient still very much exist even as she tries to minimise them. These different power relations are integral to how the texts are structured and how the voices of the people with lived experience of mental illness and distress are presented. However, the next text, *Divided Minds,* is co-produced by monozygotic twins who were brought up together. The hierarchies of power present in the other texts is missing here and this lack of obvious authority of one person over the other translates into a competitiveness between the twin-narrators, which is present in both the form and content of the memoir.

Like *Henry's Demons, Divided Minds* interchanges between the two authors, identical twins Carolyn and Pamela. Here, however, there is no preface stating a particular motive guiding the text. Indeed, Flexer writes that

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[56] Michael Flexer, 'The Schizophrenic Sign: a dialectic of semiotics and schizophrenia,' (unpublished doctoral thesis, University of Leeds, 2016), p. 167.

On first reading, it is difficult to understand the purpose of juxtaposing Pamela's narrative with Carolyn's, as the latter is – for a considerable proportion of the book – unaware of her twin's suffering, and is – for much of the remainder – unsympathetic. The only plausible objective is to demonstrate the impact of schizophrenia upon a life course, with Carolyn as the non-psychotic control experiment with identical environment and genes.[57] Unlike the Cockburns' memoir, the text does not claim to depict the "inside" and "outside" of mental illness. Rather it demonstrates the impact of schizophrenia by comparing the trajectories and achievements of the identical twins and the tensions inherent in their relationship. Paralleled narratives by and of identical twins provide yet another platform from which to investigate relationality, connection, interdependence, reciprocity, and illness. However, *Divided Minds,* in contrast to *Welcome to my Country,* depicts a quest for separation, rather than reciprocity.

The connection between Carolyn and Pamela is inherent because they are identical twins. Dona Lee Davis explains how 'for twins raised together, their senses of someoneness develop in a dyadic, coexistent mutuality, or sharing of place and space that actually begins before birth,' [58] and this coexistent mutuality must only be exacerbated for monozygotic twins, who also share the same genetics. Having developed from the same zygote, Carolyn and Pamela's personhood is presented as interlinked and their sense of self is depicted as located in each other as much as in themselves; this concentrated version of interdependency is simultaneously resented and celebrated. Both struggle with the constant comparisons made between them, yet both replicate these comparisons through incessantly talking about their bodies, personalities, and achievements in contrast to each other's. Indeed, the way in which the text is structured by the twins' interchanging voices further encourages this constant comparison and competition between them. The fraught, incessant rivalry is present throughout the memoir, starting in childhood and continuing through to the preparation of the text. For example, it was the tradition in Pamela's class in first-grade that the pupil whose

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[57] Flexer, pp. 155-56

[58] Dona Lee Davis, *Twins Talk,* (Ohio: Ohio University Press, 2014) p.9.

birthday it was got to wear a special crown for the day – a red and gold one for boys and a blue and silver one for girls. On the afternoon of her birthday, Pamela's teacher invites Carolyn to join the class so that they might both partake in the tradition. Carolyn, given first choice of the crowns, picks the blue and silver crown, leaving Pamela humiliated with the boys' one. This seemingly minor incident becomes a recurrent motif in the memoir, symbolic of one twin taking what the other had decided should be her own, and putting herself before the needs of the other.

Carolyn is particularly anxious and insecure about establishing her own identity and frequently struggles to assert herself without doing so in relation to her twin. Upon starting college Carolyn wrote in her diary that 'I have to start thinking of myself as *I,* not as *we.*' (p. 98) and this need to differentiate herself from her twin intensifies as Pamela becomes increasingly mentally ill. The twins' trajectories appear to be inversely proportional: as Pamela is more and more affected by psychoses and auditory hallucinations, Carolyn becomes more heteronormatively "successful," qualifying as a psychiatrist, marrying, and having children. Despite this (or maybe because of it), her anxiety to differentiate herself from Pamela remains. The extent of Carolyn's transformation can clearly be seen from this episode in Pamela's narrative. Pamela stands at the crack of the doorway waiting for Carolyn to arrive for her visit to the ward. Spotting her, Pamela notes how Carolyn is 'professional looking, very much the psychiatrist in her expensive narrow skirt and leather coat. [Acting] as if she's been in places like this a hundred times' (p. 262). Pamela then counts the number of seconds it will take for Carolyn to get to her room. Despite expecting her twin, to the very second, Pamela 'shriek[s] then freeze[s] like a deer in headlights' (p. 262) when Carolyn comes through the door. She narrates how 'for an instant I don't know where I am, what to do, how to protect myself, where to go… Then wonderfully, magically, right before my eyes, [Carolyn] turns into my sister again' (p. 262). Pamela's reaction of shock and fear on seeing Carolyn is extraordinary, especially given that she has just watched her walk down the corridor towards her room. The transformation from Carolyn-as-psychiatrist, smiling 'comfortably, conspiratorially' (p. 262) with the nurses, to her sister is striking. Whilst Pamela states that she does not know how to explain herself and alludes to the way in which she shifts ‘between different planes of reality,’ (p. 262) her reaction is not necessarily pathological – it could simply be the result of struggling to reconcile the image of Carolyn as composed, professional, psychiatrist, with her twin.

Carolyn is keen to establish this calm, collected, composed, professional persona whenever she visits Pamela. Later in the memoir, prior to another visit to Pamela in the psychiatric unit, Carolyn reassures herself: ‘I am “okay,” the survivor, the twin who has “made it,” and I want it to show. Make damned sure no one mistakes me for the patient. I’m *the sister,* the good sister, the married-with-two-kids-psychiatrist-and-dancer sister’ (p. 272). Carolyn’s fear of being mistaken for her twin here is callous and her use of the term ‘survivor’ is particularly loaded given that it is frequently claimed by people with psychiatric disabilities. Having been so keen to distinguish herself from Pamela, this passage is, ironically, followed by an episode in which Carolyn literally fails to recognise her twin, paralleling and exceeding Pamela’s momentary inability to reconcile the image of professional psychiatrist with her sister. Awaiting Pamela on the ward, Carolyn sees ‘a pudgy middle-aged woman’ ‘swaddled’ in layers of clothes and carrying overflowing bags ‘shuffle’ up to her (pp. 273-4). Even when the lady starts talking to her, Carolyn is still looking around the ward, trying to catch a nurse’s eye to ask where her twin is. It is only when the woman addresses her as ‘Lynnie’ that Carolyn stares at her, ‘trying to reconcile the familiar voice with this strange, bedraggled person’ (p. 274) and recognises that she is in fact her sister. The failure of one identical twin to recognise the other strikingly demonstrates the extent to which Pamela’s illness distinguishes them. Earlier in the memoir, Carolyn had already commented how they were ‘no longer identical’ (p. 184) due to Pamela’s self-mutilation of her arms. However, here Carolyn’s failure to even identify her twin emphasises their separation – both physically and emotionally; Carolyn need not have worried that she would be mistaken for Pamela. Their physical dissimilarity further increases as the side-effects of Pamela’s anti-psychotic medication include significant weight gain. Whilst Carolyn narrates that she hates seeing what she would look like if she became fat, likening seeing her twin to looking ‘in one of those “fattening” mirrors in a carnival,’ Pamela has to deal with people laughing when she tells them that she and Carolyn are twins, thinking that she is joking (p. 284). Again, Carolyn’s preoccupations are damningly superficial in comparison to Pamela’s lived experience.

The twins’ divergence is reinforced by the inclusion of photographs in the memoir. Halfway through the text, there is a series of 22 photographs tracking their lives from indistinguishable babies a few weeks old in 1952, to their mid-40s at which point they are no longer identical. This divergence is exacerbated by the choice and order of the photos included. The final photos, taken in the 1990s, depict Carolyn glamorously dressed, dancing in a ballroom competition with her coach, and a photo of Pamela underneath sitting alone with her cat dressed in dungarees with the caption ‘Pam, post-Zyprexa, 1998, with Eemie’ (p. 178). The contrast between the two could not be starker: Carolyn is established as active, social and sexual, whilst Pamela fulfils the stereotype the “crazy” cat lady.[59] The fact that the photo of Pamela is ‘post-Zyprexa’ is significant, not just in temporally locating her according to her medication, but also because this accounts for why she is not obese in the photo – self-conscious about her weight gain, Pamela did not want photos taken of her whilst she was taking Zyprexa: ‘fuck Mark and his fucking camera. I don’t want him taking any pictures where he can make me look like an elephant’ (p.285). Flexer, justifiably, comments that ‘any reader might wonder at the course of the conversation between the twins that settled on this selection and ordering of photographs.’[60] However, throughout the memoir there is little metanarrative depicting the preparation of the text.

For the most part the two accounts of *Divided Minds* are kept separate without any reflection on the processes behind the textual production, with one notable exception. In this episode, narrated by Carolyn, the twins are being observed by a reporter and photographer

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[59] Flexer (pp. 156-57).

[60] Ibid., p. 157.

writing an article on them. Tension between them breaks into an argument over the authorship of the memoir in which Pamela accuses Carolyn of not trusting her:

> "You didn't come up here to see me, you came up here to make sure I didn't claim the book was MINE!"
> *This is our* story, *our lives,* I am only a supporting actor. She's the main subject, the leading lady. *Ha! The story of my life, being number two.*' (p. 288)

This is clearly couched in the language of competition: Carolyn is the 'supporting actor' to Pamela's 'leading lady' and frustrated at 'being number two.' The equivalence drawn between text and life ('*our* story, *our lives*') is crucial. Discussing Eakin's work on narrative identity in the introduction, I explained how he argues that life writing is performative: to tell a life story, is also to live it. In the case of identical twins, where identity is especially relational, selfhood and identity are coproduced. It is consequently fitting that the text replicates this model of coproduction, and that this fractious mode of being and writing is replicated in the text's structure and creates an episode of destabilization here. Questions of ownership of life and story become even more knotted in the case of Carolyn and Pamela because these questions have plagued their whole lives, not just the production of their memoir. In *Stuart* the moments of destabilization were purposefully crafted and included in order to make the text appear more authentic and to give Stuart a voice back in his own narrative. In *Divided Minds* this moment of instability is more difficult to characterize because it is the only episode like it in the memoir. The destabilization is anomalous with the rest of the text, in which the tensions between the twins are visible, but never break through the container of the narrative. Perhaps significantly, the argument ends with the twins apologising and both in tears; after the division they come back together.

Divided Minds is characterized by a tug of war between connection and separation. Despite her efforts to distinguish herself from Pamela, Carolyn frequently refers to their interdependency and uses it as a tool by which to dissuade her from suicide: 'You can't kill yourself because you'd murder me too' (p. 263). This statement carries with it not only the surface level meaning that Pamela killing herself would cause Carolyn extreme emotional distress, but also has a more literal level alluding to their shared identity and life. Carolyn goes beyond finding it impossible to imagine a life without Pamela, stating that 'if Pammy's life is at stake, so is mine' (p. 252). Their lives are fundamentally entwined. Yet, for most of their lives the twins have lived at a distance from each other, often not seeing each other for years at a time. This distance, 'her choice as much as mine' (p. 181), Carolyn states, has been 'far enough away from her to stay in touch while safely maintaining a separate life, a separate identity. […] I think we've *both* wanted it that way' (p. 265). Geographical separation here is presented as a prerequisite for identity formation and maintenance. Proximity and distance are consequently difficult to track in this memoir: on the one hand, Carolyn's life seems permanently interrupted by Pamela's illness, on the other they live apart and go for years without seeing each other. Near the end of the memoir Carolyn reflects on this dynamic of connected separateness:

> Pammy and I, separate, have become individuals, our lives diverging more than ever imagined. Schizophrenia or not, we are still twins, still in some indefinable way part of each other, still one, connected in some mystical way, bonded through genetics no matter what. (p. 311)

However separate and divergent, their lives will always be entangled in one another's because of their twinship. The language of this quote links back to that of *Welcome to my Country*: the mystical, indefinable bond that the twins share echoes the semantics that Slater uses to describe the connection she seeks with her patients and her reader. However, the twins, inherently connected, seek separation, whereas Slater starts from a point of separation, crafts connection, and must judge when to separate again.

The trajectory of *Divided Minds* counterpoints that of *Welcome to my Country* in that it depicts a process of divergence whereas the later focuses on merging; these emphases are apparent from their titles: division versus welcome. *Divided Minds* demonstrates that co-production does not have to stress connections or affinities, although we might expect it to. It can also draw attention to tensions, separation, and divisions. This chapter has made connections between texts that provide different versions of what it means to jointly tell a story of mental illness. However, it has also been aware of the tensions and divisions, not just within the narratives, but across them. Whilst each of these pieces of life writing complement each other in an analysis of collaborative telling, the versions of co-production that they produce take extraordinarily different forms. In *Stuart* Masters self-consciously worries over how to ethically relay Stuart's experiences of abuse, addiction, incarceration, and disability whilst remaining faithful to his character and the ways in which he wanted his story to be told. The text is occupied as much with its mode of telling as with the content of its narrative. Slater, in *Welcome to my Country,* debates the ethical implications of her mode of co-production with Joseph, and in turn reflects on her appropriation of her patients' stories as means of collaboratively telling her own story of mental illness. The two familial co-produced memoirs, *Henry's Demons* and *Divided Minds*, showcase the divisions between co-producers that carry into the text; be that a fundamental disagreement between pathological and spiritual interpretations of schizophrenia, or the competition and rivalry between identical twins. Like Carolyn and Pamela, these texts are divergent, and yet connected. Once again Slater's language proves useful: this chapter too has traced the 'interactions and conflicts'[61] between subject-narrator-producers, between the narrators and their reader, and created a framework in which these texts can productively interact, affirm, and contest each other. In tracing the connecting threads running across the texts, whilst noting the spaces between them, the chapter has woven a 'complicated lattice'[62] illustrating the impact of co-production on memoirs of mental illness. This lattice emerges from the entangled issues of power, vulnerability, instability, confluence, divergence, and contestation that have marked the encounters within and outside of the texts.

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[61] *Welcome to my Country*, xii
[62] Ibid.

Chapter 3 Excess and Entanglement: visualising mental illness in graphic memoirs

Una's *On Sanity: One Day in Two Lives* (2016) is a short (40 page) graphic narrative set in Leeds about the day that her mother was committed to a psychiatric unit.[1] The text is split in two: the first part is based on a zine that Una made in 2008 entitled *Family Fun: On Sanity* about the day her mother was sectioned; the second is based on an oral history recording of her mother's retrospective perception of the same day. When Una made the original zine the extent to which her mother's mental health would improve was unclear; however, 'now that she has recovered so well,' Una writes in her afterword, 'it seems right that she should tell her half of the story'.[2] There are clear links then between this familial memoir and those discussed in the previous chapter. For example, the blurb, which simply states 'One mother, One daughter, One day, Two perspectives' speaks back to the framing of both *Divided Minds* and, even more so, *Henry's Demons*. Whilst *On Sanity* never claims to provide the "inside and outside" of mental illness (it is too thoughtful to be so reductive), it works from a similar logic, aiming to showcase two different sets of memories and interpretations of one person's mental health.

As with all the texts in the previous chapter, this memoir centres on a relationship – in this instance between Una and her mother – and, like *Welcome to my Country* and *Stuart*, foregrounds connection and dialogue. Relationality is even more foundational here because, being a graphic memoir, *On Sanity* relies on the relationship between image and text to a much greater extent than any of the prose narratives discussed thus far. In my analysis of *Stuart*, I wrote briefly about the impact of multimodality in the memoir, arguing that Masters' inclusion of Stuart's handwriting and drawing injected humour and strongly asserted Stuart's

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[1] In the opening of her own memoir about mental illness and sexual violence, Una writes: 'my name is Una. Una, meaning one. One life, one of many.' Una, *Becoming Unbecoming* (Oxford: Myriad, 2015), p. 3.

[2] Una, *On Sanity: One Day in Two Lives* (Leeds: Becoming Press, 2016), no page numbers.

presence in the narrative. Rather than occasional drawings and excerpts being interspersed throughout a prose narrative, *On Sanity* is a constant conversation, not only between mother and daughter, but also between the varying visual and textual elements on the page.

In her section, which opens the text, Una criticises contemporary psychiatry's tendency to focus on pharmaceutical solutions to mental illness and asks what would happen if we engaged with individuals' interpretations of their own distress. Citing the work of Gregory Bateson, Una frames madness as the product of familial dynamics and presents her mother as someone who has woven a new reality as a coping mechanism.[3] Rather than supressing this alternate reality with psychopharmaceuticals, Una asks that we journey with the individual and listen to their story, in this case her mother's. This is accompanied by an image of Una's mother leading Una by the hand over a hill. This image has been repurposed from Una's own memoir of mental illness and sexual violence, *Becoming Unbecoming* (2015) in which she situates her own history of sexual abuse in the context of the hunt for the Yorkshire Ripper.[4] The intertextual use of this image adds yet another degree of relationality, across Una's own work, and means that, for some readers, Una and her mother's avatars are recognisable without being explicitly introduced. This drawing is followed by a wordless sequence that unfolds over five full sides in which Una and her mother are trapped in a dark,

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Figure 6: Una's mother leads her by the hand

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[3] In particular, Una cites Bateson's 1956 theory of the double blind, see: Gregory Bateson et al., 'Toward a theory of schizophrenia,' *Behavioural Science*, 1.4 (1956), 251-64.

[4] Una, *Becoming Unbecoming*, p. 25.

claustrophobic passageway and Una’s mother, with hammer and chisel, tunnels her way out into a new landscape. The sequence establishes the visual metaphor of digging oneself out of one reality into another and emphasises Una’s focus on journeying with someone experiencing psychological distress, as well as the limits of how far they can be accompanied.

Una’s focus then shifts to the day on which her mother was sectioned. She narrates how she and her mother sat at the kitchen table drinking tea and eating biscuits while the medical team outside decided whether to detain her mother under section 2 of the Mental Health Act. Una remembers being anxious about keeping her mother relaxed and in the kitchen to prevent her from being agitated by her sister in the next room, or from seeing the police officers outside the house in case she then tried to run away. Her mother, on the other hand, seemed unaware of the practicalities of the situation and was apparently satisfied that ‘she’d been proved right about the global conspiracy against her.’ ‘For several hours,’ Una writes, she and her mother sat there awaiting the decision while Una hid her own distress. Una’s whole narration of the day her mother was admitted takes up only two sides of the memoir and features predominantly to set the scene for her mother’s version of the day. This scene setting takes on a literal dimension as the images accompanying Una’s narration are areal sketches of her mother’s house and floorplans that map where she, her mother, her aunt, and the social worker were in the house as they waited for the paperwork to be completed and transport to arrive.

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Figure 7: Floor plan setting the scene

In the next section, which carries the subheading '*the same day in another perspective*,' the narrative switches to her mother's account of the day's events. Here Una still draws the images, but the words are her mother's. This section is much more detailed and descriptive. In her transcribed narrative, Una's mother narrates the whole day in a meandering manner, including having a fight with her brother, writing poems and drawing pictures and cartoons, making a sculpture, and defacing the family photo albums with swastikas because she had decided that her relatives were Nazis all before Una, the medical team and social workers arrived in the afternoon and her subsequent admission.[5] Una gives more space in this section to the story her mother created in the morning – which featured her grandsons as gangsters, Una as the Aztec goddess Cihuacoatl and her sister as a cowgirl – than to her own narrative of the eponymous day. Similarly Una gives her mother time and space to talk about her sculpture, which she made using a tailor's dummy and a white marque, and fastened high up on the walls to look like an angel with spread wings. She put a wig and jewellery on the dummy and broke some eggs and sprinkled burnt toast on it. She imagined the sculpture as her own mother Hilda, saying 'the eggs were to do with being a mother, and birth, and… eggs. I don't know how to explain that but it was to do with being a mother, and the burnt toast… was my mother.' When structuring the memoir, it would have been easy for Una to minimise the detail of her mother's stories and sculpture, skimming over them to focus on the events of her admission in the afternoon. However, Una's sustained engagement with these memories enacts her willingness to be led by her mother and listen to her perspective of the day. In her afterword, Una writes that her mother's consultant lacked any interest in her mother making these objects, which Una finds confusing because they clearly spoke to specific anxieties occupying her mother at the time. By dedicating the space and detail (both textual and visual) to these artefacts, Una resists imposing a diagnostic judgement about what was parenthetical to that day.

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[5] Una never refers to her mother by her name, Margaret, in the memoir, only ever by 'Mum' or 'Mother', which further emphasises the relationality underpinning the text.

As well as the two parts of the memoir coming together to form a structural dialogue, the section written from Una's mother's perspective reads as a conversation. *Stuart*, as I have discussed, is characterised by Alexander asking questions that Stuart refuses to answer. *On Sanity* frequently uses a question and answer format, but the dynamic is different, partly due to the graphic form. On two occasions Una covers, or nearly covers, the page in speech bubbles, with her voice written and outlined in grey, and her mother's in black. This way of staging a conversation between her and her mother is unique to the comics form and enacts the to-ing and fro-ing of dialogue in a way that prose struggles to achieve. Elsewhere in her mother's section, Una occasionally interjects a question, frequently contained within a speech bubble and often emanating from the side of the page. Her mother's response, in contrast, is written out in paragraphs as the main body of the text. In this way Una's questions are (literally) contained and act as prompts that open up room for her mother to speak, for example this page, in which Una and her mother are sitting at the kitchen table.

In a speech bubble layered on top of the drawing, Una asks 'what did you think, in the afternoon when I came, and we sat in the kitchen, drinking tea?' Her mother is then given the space to reply at some length that she had presumed that Una had come to 'calm things down' and that she had felt 'quite content' and 'happy to sit with [her] daughter, reading the newspapers and chatting'. The inclusion of the image situates and embeds the conversation; again we see how the graphic form enables a different way of staging and locating dialogue. Furthermore, the image also speaks back to Una's section in which she drew the tessellating floorplan of the house that included her and her mother seated at the kitchen table. In Una's depiction the reader is distanced from the scene, looking down, and the figures, were it not for the accompanying text, could be anyone. Here, in her mother's section, Una draws in much more detail and invites the reader into the scene. The different ways of presenting the two of them sitting across from each other at the table emphasises their contrasting feelings; in her section Una wrote that she 'acted as if everything was quite as it always had been' while her 'distress devoured [her]… silent, unseen' whereas her mother remembers being 'content,'

Figure 8: Una and her mother sat at the kitchen table

‘glad,’ and ‘happy’. The domestic focus on the two of them at the kitchen table also nods to the process behind the production of the memoir. In her afterword, Una writes that she and her mother made the oral history recording, on which her mother's section is based, at her kitchen table over tea and biscuits. Granted, the conversation takes place at a different kitchen table, but it seems fitting that the process behind the memoir reclaims this encounter between mother and daughter.

On Sanity situates mental illness amongst the domestic and ordinary. Una's detailed drawings of the house's exterior, floor plans, hallways, and the kitchen firmly locate her mother's narrative of mental distress at home. Her attention to the eggs and burnt toast used to make the sculpture, and her repeated emphasis on tea and biscuits privileges the domestic and everyday. Conversely, the clinical is marginalised. Having spent considerable time (relative to the length of the narrative) unpacking Una's mother's morning and the events leading up to her sectioning, the memoir spends only five pages detailing her admission and memories from within the unit. In contrast to the richness of the depiction of their family home, Una's drawings of the unit, contained within two sides of the memoir, are stripped back and minimal. They show Una, her mother, and two people in uniform going up in a lift, her mother sitting on a bed and in front of a buffet table, and having a fight with another patient about what to watch on television. The relative starkness of the drawings is not because the unit was unpleasant – Una's mother remembers 'being pleased when [she] saw [her] bedroom because it was really nice', and continues 'I though this is better than any hotel I've ever stayed in. I don't mind being here,' – but is part of the text's implicit privileging of the domestic over the clinical. Aside from the illustrations of the lift, there are no drawings of Una's mother interacting with any healthcare professionals, neither is there any mention of her diagnosis or treatment plans, nor, as I will come back to in the conclusion of this chapter, her recovery. *On Sanity* minimises and contains the clinical and biomedical aspects of Una's mother's mental distress, instead prioritising the home, and the relationship between mother and daughter.

As I have shown, the visual nature of this comic book emphasises the central relationship that underpins the narrative, that of Una and her mother. The visual highlights the bond between the two because their bodies (avatars) are repeatedly depicted next to, or interacting with, one another. Una and her mother are literally situated in relation to each other on the page, whether this be one leading the other by the hand, next to each other but at some distance in a tunnel, across from each other at a kitchen table, or in the same lift in a psychiatric unit. The way the visual medium stresses the embodied nature of the encounters between subject/narrators extends my discussion of interdependency and relationality in co-produced prose texts in the previous chapter. Relationality and embodiment will remain central to my analysis of the depictions of mental illness in the graphic memoirs that follows. Both singularly authored, neither of these comics depicts a relationship between collaborators, but they do stage similar encounters between multiple versions of themselves engaging with each other (usually an avatar of an older narrator looking back at their younger self). It is this process, I will argue, that exemplifies the way comics work as visualised acts of witnessing illness and sexual violence.

Turning towards the visual: what the graphic brings to narratives of mental illness

I have used *On Sanity* to introduce this chapter's focus on narratives of mental illness that have an emphasis on a visual, as well as, or instead of, a verbal mode of storytelling. Throughout the thesis there has been an increasing focus on the visual and multimodal elements of texts – this was present from the beginning, of course, with Kaysen's photocopies and Washuta's experimentation with layouts and typefaces, continued through the photographs in *Henry's Demons* and *Divided Minds*, and was most evident in *Stuart* with its combination of cartoons, handwriting, and text. Given that the thesis has analysed the various forms through which people construct and communicate narratives of their emotional and psychological distress, it is fitting to deepen my analyses by paying attention to visual articulations of mental illness. I do this specifically with an awareness of the current visual turn taking place within the critical medical humanities and to demonstrate how sustained attention to the visual extends and enriches discussions of illness narratives.[6] Comics are yet another form through which people experiment with life writing to narrate experiences of mental illness and histories of trauma, and, as I have begun to demonstrate, have access to a much vaster array of tools through which to construct those narratives.

In this chapter I return to many of the themes that have arisen from my discussions of prose memoirs and explore how they are framed by the comics form. As such, I analyse the implications of diagnoses to identity, the intersections of sexual violence and mental illness, and the dynamics of relationality. To do so I use Ellen Forney's *Marbles: Mania, Depression, Michelangelo & Me* (2012), and Katie Green's *Lighter than My Shadow* (2013). *Marbles* is the most well-known and acclaimed graphic narrative of mental illness. It is a memoir about Forney's diagnosis of bipolar disorder and its impact on her life and identity as an artist, which contains pieces of advice and coping mechanisms alongside descriptions and illustrations of her moods. Katie Green's *Lighter than my Shadow* is a coming-of-age narrative about anorexia and sexual assault in which she traces her disordered eating, diagnosis, interactions with healthcare professionals, recovery, relapse, and slower, more provisional recovery. Green also details her abusive relationship with an alternative therapist who repeatedly sexually assaults her during their sessions.

Both of these graphic narratives has multiple points of connection with memoirs already examined in this thesis. *Marbles* links back to *My Body is a Book of Rules* in terms of how Forney and Washuta relate to their diagnosis of bipolar. Both accept that their diagnosis provides a useful framework in which to contextualize their moods, but also detail their struggles with finding the right balance of medications to reach stabilization and the difficulties of drug compliance. *Lighter than my Shadow* also links to *My Body is a Book of Rules* in the ways that Green narrates the intersections of disordered eating and the repercussions of

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[6] Fiona Johnstone, 'Manifesto for a Visual Medical Humanities', *Blog: Medical Humanities*, 31 July 2018 < https://blogs.bmj.com/medical-humanities/2018/07/31/manifesto-for-a-visual-medical-humanities/> [accessed 8 August 2019].

sexual abuse. Though drawing on different formal techniques, both make the violence that they have experienced explicit on the page and experiment with how to portray the aftermath of trauma within their narratives.

Examining graphic narratives in this chapter also gives me the opportunity to explicitly engage with the embodied nature of mental illness. So far, I have focused on the impact of mental distress on narrative and subjectivity in prose memoirs. Whilst mental illnesses are always embodied experiences, it is easy to minimise the impact of the illness on the body, unless explicitly emphasised by the author of a text-based narrative.[7] However, in comics, as I will demonstrate, the body, its relationship to identity, the ways it registers illness and distress, and its interactions with others, are made conspicuous. As Amelia DeFalco has illustrated, comics is a genre 'uniquely positioned for bodily narration since its combination of words and images produces a hybrid form able to represent narrative *and* materiality simultaneously.'[8] Numerous comics scholars have emphasised the centrality of the body to the form, including Susan Squier, Elisabeth El Refaie, Hillary Chute, and Ian Williams. Squier argues that 'in their attention to human embodiment, […] comics can reveal unvoiced relationships, unarticulated emotions, unspoken possibilities, and even unacknowledged alternative perspectives.'[9] El Refaie emphasises how drawing autobiographical avatars forces the creator to explicitly engage with their own physicality,[10] and Chute highlights the presence of the artist's body on the page through their hand-drawn lines.[11] Taking a different approach to embodiment, disability studies scholars Dale Jacobs and Jay Dolmage have analysed how comics draw

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[7] It is striking, for example, that both Washuta and Slater talk about their experiences of eating disorders, and yet, it is only in this chapter, where anorexia is depicted pictorially that I spend time analysing its representation.

[8] Amelia DeFalco, 'Graphic Somatography: Life Writing, Comics, and the Ethics of Care', *Journal of Medical Humanities*, 37 (2016), 223-40 (225).

[9] Susan Squier, 'Literature and Medicine, Future Tense: Making it Graphic', *Literature and Medicine*, 27.2 (2008), 124-52 (p. 130).

[10] Elisabeth El Refaie, *Autobiographical Comics: Life Writing in Pictures* (Jackson: University Press of Mississippi, 2012), p. 8.

[11] Hillary Chute, *Graphic Women: Life Narrative and Contemporary Comics* (New York: Columbia University Press, 2010), p. 10.

attention to the diversity of bodies and the intersections of trauma and physical impairment.[12] However, there has been little work examining how mental illness and distress is registered on the body in graphic narratives. The ways in which the inextricability of narrative and materiality, mind and body, is foregrounded in comics makes it an ideal form for analysing representations of mental illness and disability.

Inspired by trauma studies, and wanting to emphasise the importance of mental disability in disability studies, Margaret Price started using the term ‘bodymind’, mentioned previously in the thesis, to indicate the enmeshment of mental and physical processes. Price argues that ‘because mental and physical processes not only affect each other but also give rise to each other […] it makes more sense to refer to them together, in a single term’.[13] Bodymind, Price argues, works towards a more capacious form of crip theory in its inclusion of mental disability, and its ability to acknowledge pain that arises from some experiences of disability. Sami Schalk has recently extended the concept in the context of black women’s speculative fiction because of the term’s theoretical utility for discussing the intersections of race and disability.[14] In this chapter, an engagement with the concept of bodymind will deepen my analysis of graphic representations of illness, disability, and trauma, both in terms of how the body expresses symptoms of mental illness, and in relation to how experiences of mental illness run parallel to and intersect with histories of abuse.

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[12] Dale Jacobs and Jay Dolmage, ‘Difficult Articulations: Comics, Autobiography, Trauma, and Disability’, in *The Future of Text and Image: Collected Essays on Literary and Visual Conjunctures*, ed. by Ofra Amihay and Lauren Walsh (Newcastle upon Tyne: Cambridge Scholars Publishing, 2012), pp. 69-92.

[13] Margaret Price, ‘The Bodymind Problem and the Possibilities of Pain’, *Hypatia*, 30.1 (2011), 268-84, p. 269.

[14] Sami Schalk, *Bodyminds Reimagined: (Dis)ability, Race, and Gender in Black Women’s Speculative Fiction* (Durham: Duke University Press, 2018).

How comics work and the autobiographical work they do

Within the medical humanities, disability studies, and literary studies more broadly, there has been increasing recognition of the potential of graphic narratives as source material.[15] Whilst once comics were viewed in a somewhat derogatory critical light, increasing awareness of their aesthetic potential and ability to communicate complex histories has established their status as cultural texts with something to say. This growth of a critical awareness of comics' potential has been largely due to a number of graphic narratives that narrate histories of cultural trauma such as Art Spiegelman's *Maus* – first serialized in *Raw* magazine between 1980 and 1991, later published as books 1986 (volume 1) and 1991 (volume 2) – which depicts personal stories of life during the Holocaust and intergenerational trauma; Joe Sacco's *Palestine* (1993) – a piece of graphic journalism based on his time spent in the West Bank and Gaza Strip in the early 1990s – and Marjane Satrapi's *Persepolis: The Story of a Childhood* (2003), a memoir about growing up during Iran's Islamic Revolution.[16] More recently scholars have awoken to the possibilities arising from comics that portray narratives of illness and disability.

Whilst it is not the task of this chapter to provide an in-depth history of comics or a lesson on their form, I need to briefly outline the grammar of comics because it is foundational to my analysis. "Comics" refers to the medium itself, rather than any specific content or object, and as such is used with a singular verb.[17] In his seminal *Understanding Comics: The Invisible Art*, Scott McCloud defines comics as: 'juxtaposed pictorial and other images in deliberate sequence, intended to convey information and/or produce an aesthetic response in the viewer'.[18] McCloud's definition is purposefully broad in that it refuses to specify genre, subject

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[15] See for example, Susan Squier, 'So Long as They Grow Out of It: Comics, The Discourse of Developmental Normalcy, and Disability', *Journal of Medical Humanities*, 29.2 (2008), 71-88. Gillian Whitlock and Anna Poletti, 'Self-Regarding Art', *Biography*, 31.1 (2008), v-xxii.

[16] See Gillian Whitlock, 'Autographics: The Seeing "I" of the Comics', *Modern Fiction Studies*, 52.4 (2006), 965-79.

[17] Scott McCloud, *Understanding Comics: The Invisible Art* (New York: Harper Collins, 1993), p. 4, p. 9.

[18] Ibid., p. 9

matter, style, technique, materials, or tools as part of comics' designation.[19] He also, somewhat controversially, argues that comics do not have to contain words.[20] More recently Chute suggests this definition: 'a hybrid word-and-image form in which two narrative tracks, one verbal and one visual, register temporality spatially'.[21] Chute agrees with McCloud that comics do not have to include words, but recognises that the vast majority of them do, and argues that the much of the work of comics is found in the interplay and tensions between the words and images on the page. Like Chute, both Krista Quesenberry and Squier emphasise that the visual and the verbal modes of representation in comics are frequently discordant and nonsynchronous; the words do not have to echo, amplify, or stabilise the image (although they can do each of these things), but can also undercut and complicate them.[22] This interplay between the visual and the verbal, and the multiple directions, possibilities, and dissonances that it affords is at the core of graphic narrative. Crucial to both McCloud and Chute's formal definitions is the need for sequence, and this is where comics differs from the cartoon. A cartoon is a single image that stands alone, whereas in comics the images (and text) exist in relation to each other for their meaning. Interdependency is then foundational to the comics form, and, as I have started to show, this adds another dimension to my analysis of relationality in narratives of mental illness that runs throughout this thesis.

Interacting with comics is an altogether different experience from reading a prose narrative. As Chute notes, when one turns comics page, the eye instantly takes in the whole grid of panels and any particularly emphasised features before starting to read sequentially from the first box of the first tier. Consequently, comics involve looking and then looking again, building a 'productive recursivity' in their narrative engagement.[23] Comics can be picked up,

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[19] Ibid., p. 22

[20] Ibid., p. 8

[21] Hillary Chute, 'Comics as Literature? Reading Graphic Narrative', *PMLA*, 123.2 (2008), 452-65.

[22] Krista Quesenberry and Susan Merrill Squier, 'Life Writing and Graphic Narratives', *Life Writing*, 13.1 (2016), 63-85.

[23] Chute, *Graphic Women*, p. 9.

put down, and flicked through in a way that prose resists. This also distinguishes the form from film, to which comparisons are often made, as the pace of consumption here is dictated by the reader; comics are not experienced in a stipulated time frame and this can result in ethical as well as aesthetic differences when the narrative is about trauma.[24] The immediacy of the visual image makes comics feel more accessible than prose narratives, and a reader's initial response to them is perhaps more immediate and instinctual. Comics are often praised for being 'engaging, powerful and accessible,'[25] and yet this emphasis on the form's accessibility and approachability should not undermine its formal sophistication and complexity.[26]

Comics progress in time across the space of the page,[27] with panels indicating that time and/or space is being partitioned.[28] Panels, otherwise known as frames, can be various shapes and sizes, bordered or borderless, and placed in different arrangements, and each of these factors will alter how the content of the panel is perceived by the reader. Panels are (predominantly) self-contained and separated by a blank space, which is called the gutter. Consequently they create what McCloud calls a 'staccato rhythm' of encapsulated moments.[29] It is up to the reader to provide 'closure' between the panels, filling in the gaps to create a continuous narrative. This alternation between presence (the content within the frame) and absence (the space between them), and the subsequent need for the reader to 'project causality,'[30] means that the creator is hyper-aware of what has to be shown and what can be implied whilst shaping the narrative. The elliptical nature of the comics sequence (alternating between presence and absence) creates what Charles Hatfield has described as a 'fractured

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[24] Ibid., p. 9.

[25] Ian Williams, 'Graphic medicine: comics as medical narrative,' *Medical humanities* 38 (2012) 21-27, p. 25.

[26] Charles Hatfield, arguing that emphasising the ease and simplicity of comics overlooks their complexity, differentiates between *skimming* comics and *reading* comics. *Alternative Comics: An Emerging Literature* (Jackson: University Press of Mississippi, 2005), p. 67.

[27] Chute, 'Comics as Literature?', p. 452.

[28] McCloud, p. 99.

[29] Ibid., p. 67.

[30] Chute, 'Comics as Literature?', p. 460.

surface' on the page, made up of a 'patchwork' of images, shapes, symbols, and text that results in a 'a surfeit of interpretive options' and an 'experience that is always decentered, unstable, and unfixable'.[31] Comics' reliance on the reader to join the dots (or frames), and the various elements within them, means that it requires an active, participatory mode of narrative interpretation that frequently demands slowing down and rereading.[32]

Comics scholars trace the origins of contemporary autobiographical comics back to the underground arts movement in San Francisco of the late 1960s. The movement emerged in response to the federal censorship enacted by the 1954 Comics Code, which aimed to erase representations of violence and sex in comics. Arising in response to the censorship of the code, the 'underground comix revolution,' rejected mainstream publication, and experimented with new forms and darker, grittier themes.[33] Citing the work of Robert Crumb and Harvey Pekar, Jared Gardner argues that the early 1970s were a watershed moment for the development of contemporary autobiographical comics.[34] In particular, Gardner, alongside many others, argues that Justin Green's *Binky Brown Meets the Holy Virgin Mary* (1972) paved the way for a new generation of creators to draw on taboo personal experiences in their work.[35] Frequently credited as being the first graphic autobiography, *Binky Brown* is also, somewhat coincidentally, a narrative of OCD. In the comic Green's alter ego, Binky Brown, suffers from a compulsive neurosis in which he sees ordinary objects as phalluses emitting rays (drawn as a kind of laser beam) that must be avoided at all costs. It was only after the publication of the comics that Green was diagnosed with OCD and came to view his experiences in line with the condition.

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[31] Hatfield, pp. xiii-xiv.

[32] McCloud, p. 69.

[33] For a fuller, more accessible history of comics' development see Hillary Chute and Marianne Dekoven, 'Comic Books and Graphic Novels,' in *The Cambridge Companion to Popular Fiction*, ed. David Glover and Scott McCraken (Cambridge University Press, 2012), pp. 175-95.

[34] Jared Gardner, 'Autography's Biography, 1970-2007', *Biography*, 31.1 (2008), 1-26.

[35] Williams, *comics as medical narrative*, Quesenberry and Squier, and Chute, *Graphic Women*, pp. 16-20 all argue that Green's narrative is foundational.

This comics touchstone directly influenced many other artists to draw upon autobiographical experiences in their work including Spiegelman, Aline Kominsky-Crumb, Lynda Barry, Phoebe Gloeckner, and Alison Bechdel. Chute analyses Kominsky-Crumb, Barry, Gloeckner, and Bechdel in her brilliant extended analysis of women's graphic life writing.[36] Strikingly, all of these creators write about trauma and sexuality, with an emphasis on chaotic and messy bodies, and narrate a substantial portion of the text from the perspective of their child selves. This is also true of *Lighter than my Shadow* and my analysis of the intersections of illness and trauma in Green's memoir will build upon Chute's analysis of these creators' feminist representations of the complexities of abuse. These works and the abundance of others like them demonstrate that comics lends itself to life writing, and is particularly adept in telling traumatic narratives. Building on Gilmore's theorization of "autobiographics," discussed in chapter one, Whitlock coined the term "autographics" to emphasise the specific interactions of the visual and verbal in comics autobiography and to draw attention to the subject positions occupied by narrators in the form.[37] Bechdel, author of the much acclaimed memoir *Fun Home: A Family Tragicomic* (2006), a memoir about suicide, OCD, and homosexuality, is often quoted as saying that she has 'always felt like there was something inherently autobiographical about cartooning, […] like it almost demands people to write autobiographies,'[38] and Chute argues that, regardless of whether the narrative is autobiographical, the handwriting in comics carries 'a trace of autobiography in the mark of its maker'.[39] Creators and scholars both argue that comics provide flexible spaces for materializing life narratives.

Comics have a different kind of relationship to life writing than prose narratives because of the ways that authors can experiment with the graphic form. Critics have argued

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[36] Chute, *Graphic Women.* Chute also includes a chapter on Satrapi's *Persepolis*.

[37] Whitlock, *Autographics*, p. 966.

[38] 'The Alison Bechedel Interview' *The Comics Journal* (April 2017) <http://www.tcj.com/the-alison-bechdel-interview/> [accessed 12/09/18]

[39] *Graphic Women*, p. 10.

that comics is more malleable and capacious than prose because its composition capitalizes upon the numerous interactions between different elements on the page, and what is missing from the page; the simultaneous, multiple, frequently conflicting, voices presented in thought bubbles, speech balloons, and captions; and the layering of temporalities.[40] Comics' make-up 'renders textualization conspicuous'.[41] Whilst this is potentially more inherent to the comics form, the selection of prose memoirs in this thesis demonstrates that textual modes of life writing can also highlight their own construction and materiality. Nonetheless, because of comics' emphasis on its own textualization and the ramifications of the image-text relationship, it further complicates issues at the heart of life writing, for example authentication, management of conflict, and the pace, arc, and forward momentum of narrative.[42] The tensions between historical facts, memories, and exaggerations or fabrications present in life writing are further strained in comics because of its hybrid visual-verbal form and its emphasis on exclusion as well as inclusion; consequently, comics have a different relationship to testimony.[43] Additionally, the presence of multiple autobiographical avatars on the pages problematizes the notion of a continuous self, and draws attention to the friction between narrator, subject, and author, which is more easily glossed over in prose texts.

One of the most immediate and crucial differences between graphic and prose autobiographies is that in comics the creator draws themselves on the page. This is an obvious point, but it fundamentally complicates the form's relationship to ideas of self, or selves.

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[40] See Rocco Versaci, *This Book Contains Graphic Language: Comics as Literature* (London: Continuum, 2007).

[41] Chute, 'Comics as Literature?', p. 457.

[42] Quesenberry and Squier.

[43] Gardner argues that 'the kinds of truth claims that are fought over in the courts of law and public opinion with text-based autobiography are never exactly at issue in graphic autobiography. The losses and glosses of memory and subjectivity are foregrounded in graphic memoir in a way they never can be in traditional autobiography.' (p. 6). Consequently, the issues I discussed in chapter 1 around truth and testimony in life writing are less fraught in comics because they self-consciously experiment with the permeability between fact and fiction, and, I conjecture, because they are taken less seriously than written testimony. Again, my choice of prose memoirs has been exceptional in that many of them are explicitly concerned with the blurriness of autobiography, however, this seems to be something that is more expected and accepted of comics.

Through these autobiographical avatars, 'we *see* how the cartoonist envisions him or herself; the inward vision takes on an outward form. This graphic self-representation literalizes a process already implicit in prose autobiography'.[44] Whilst we recognise that the memoirist characterizes themselves in prose, the process is much more blatant in comics because of the caricature on the page. Hatfield argues that this cartoon self-image provides a 'unique way for the artist to recognize and externalize his or her subjectivity,'[45] and El Refaie calls comics a process of 'pictorial embodiment' because of the explicit engagement the creator has to have with their body and its relation to their selfhood.[46] Having to depict yourself over and over again in different poses and situations prompts a different kind of interaction with your sense of identity and self-image; particularly when the author poses and takes photos of themselves for each panel, as Forney did for *Marbles*.[47] The autobiographical avatar is created, Hatfield argues, by the cartoonist projecting and objectifying their sense of self, and this results in a sense of both intimacy and critical distance.[48] This fraught tension between the intimacy involved in portraying the self and the processes of objectification necessary to do so dominates the creator's relationship to their cartoon self/selves.[49] The connection and separation between the avatar and creator literalizes the distinction between the 'I' of the creator and the 'I' on the page, which is frequently minimized in prose autobiography. The cohesion of the autobiographical subject is further disrupted in comics when there are multiple avatars of different ages on the page, for example the adult artist looking back at the child subject, or when authors use alter egos in their memoirs (for example, Justin Green's protagonist is called Binky Brown and yet the text is a memoir). Due to the complexity of the

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[44] Hatfield, p. 114.

[45] Hatfield, p. 115

[46] *Autobiographical Comics*, p. 8

[47] Paul Merton, 'Immersion Therapy: The Millions Interviews Ellen Forney' *The Millions* (26 June 2013) <https://themillions.com/2013/06/immersion-therapy-the-millions-interviews-ellen-forney.html> [accessed 1/6/18].

[48] Hatfield p. 115.

[49] I use 'self/selves' to draw attention to the multiplicity of the selves in comics.

relationship between narrator, subject-avatar, and author, I will make the distinction between author and subject in my writing, in keeping with practice by other comics scholars; as such, I will refer to the creator of *Marbles* as 'Forney' and the character within it as 'Ellen'.

Quesenberry and Squire point to many of these issues in an experimental piece of epistolary criticism in which they discuss the shared concerns and differing approaches between life writing in prose and graphic narratives. Constructed from an email exchange, their article draws attention to the collaborative processes underpinning both comics and scholarship on them. They argue that graphic narratives and life writing, as multi-media and multi-genre endeavours, draw attention to non-normative representations of bodies, identities, and experiences that have frequently been marginalised and overlooked in other disciplines of literary study. As such, they continue, 'since comics and life writing are already outside of some of the norms of narrative and literary traditions, they can open up understanding of "a life" – as well as "a body," "an experience," "a story" – that are not only more inclusive but also less normatively expressed, circulated, and discussed'.[50] Consequently the graphic form is particularly suited to narratives of illness, disability, and care, and the proliferation of narratives dedicated to these topics has given rise to a subgenre of comics scholarship called graphic medicine.

Graphic medicine, as described in the *Graphic Medicine Manifesto*, is 'the intersection of the medium of comics and the discourse of healthcare'.[51] Following in the vein of narrative medicine, scholars and practitioners in this field attend to the use of comics in healthcare training and communication. While narrative medicine focuses on the written, graphic medicine 'can access those aspects of illness and medicine that we experience visually and spatially, as enduring, if intractable, aspects of the patient experience'.[52] Coining the phrase

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[50] Qusesnberry and Squier, p. 15

[51] *Graphic Medicine Manifesto*, ed. by MK Czerwiec and others, (Pennsylvania: The Pennsylvania State University Press, 2015), p. 1.

[52] Susan Squier, 'The Uses of Graphic Medicine for Engaged Scholarship,' in *Graphic Medicine Manifesto,* ed. by MK Czerwiec and others (Pennsylvania: The Pennsylvania State University Press, 2015), pp. 41-66

‘graphic pathographies,’ Michael Green and Kimberly Myers argue that comics memoirs about illness, due to their economy of communication, can foster empathy, teach students observational skills, educate patients about their illness, and provide social critiques of the medical profession.[53] Elsewhere Green has argued that teaching comics to medical students provides them with a means of reflection and increases their faculties of interpretation, and, also in the educational setting, Maria Vaccarella provides a case study indicating that learning to read graphic pathographies facilitates students’ understanding of narrative temporality.[54]

As well as being an approach to educating health care professionals, graphic medicine scholars describe the field as ‘a movement for change that challenges the dominant methods of scholarship in healthcare, offering a more inclusive perspective of medicine, illness, disability, caregiving, and being cared for’.[55] It seeks disruption in multiple capacities: to disrupt the dominant assumptions of linear progress, to disrupt the overwhelming discourses of techno-medical improvement, and to challenge the “objective” case study. It also proudly resists a universalising concept of the patient and their experience, instead embracing multiple and conflicting perspectives. Graphic medicine’s essence, then, lies in its multiplicity of subject, point of view, and aesthetics. Part of this multiplicity means that it is also a scene of merging, in which personal and pedagogical, subjective and objective, image and text come together and cross over, where they have otherwise been kept separate. By encouraging boundary crossings and re-crossings, multiplicity, contradictions, and entanglements graphic medicine situates itself as an inclusive and more accessible space in which to think through the messy complications of medicine, illness, disability, and care.

(p. 46). Squier goes onto illustrate the benefits of graphic medicine, not just in the medical humanities, but also in disability studies, women’s studies, science technology studies, and animal studies.

[53] Michael Green and Kimberly Myers, ‘Graphic Medicine: Use of Comics in Medical Education and Patient Care’, *BMJ*, 340 (2010), 574-7.

[54] Michael Green, ‘Teaching with Comics: A Course for Fourth-Year Medical Students’, *Journal of Medical Humanities*, 34.4 (2013), 417-67. Maria Vaccarella, ‘Exploring graphic pathographies in the medical humanities’, *Medical Humanities*, 39.1 (2013), 70-71.

[55] *Graphic Medicine Manifesto*, p. 2

Doctor and cartoonist Ian Williams has made multiple invitations to academics working in the medical humanities to engage with comics about illness and graphic medicine. As well as contextualising graphic medicine within a brief history of portrayals of medicine in comics from the 1920s, to the underground comix, to the use of comics during the HIV/AIDS crisis, and the continuing contemporary trend in graphic pathographies,[56] Williams provides a list of annotated examples of illness comics including: David B's *Epileptic* (1996), Brian Fies *Mom's Cancer* (2006), Miriam Engelberg's *Cancer made me a shallower person* (2006), David Small's *Stitches* (2009), and Ken Dahl's *Monsters* (2009), and has suggested how they might open up discussions in the medical humanities.[57] He argues that 'comics offer an engaging, powerful and accessible method of delivery and consumption of [illness] narratives' that are 'ideally suited' to educating both health care professionals and the public, and may provide solace for people who are going through similar experiences.[58] Elsewhere he argues that comics about illness create an unofficial iconography of medicine that challenges the perceived "objective" discourses of healthcare and reclaims the power of representation of illness.[59] He has also published two comics books, one of which is a narrative of his own experiences of OCD.[60]

My concern with graphic medicine is its tendency to replicate narrative medicine's appraisal of literary illness narratives based on their use value. Whilst graphic medicine is more sophisticated than narrative medicine in its embrace of multiplicity, blurriness, and contradiction, the majority of scholarship within the field focusses on the uses of comics for therapeutic, teaching, and communication purposes in healthcare contexts. I do not want to diminish from the work that comics perform in these contexts, but rather caution against the

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[56] Ian Williams, 'Graphic Medicine: The Portrayal of Illness in Underground and Autobiographical Comics,' in *Medicine, Health, and the Arts: Approaches to the Medical Humanities,* ed. by Victoria Bates and others (London: Routledge, 2014), pp. 64-84.

[57] Williams, *comics as medical narrative*, pp. 22-26.

[58] Ibid., p. 27.

[59] Ian Williams, 'Comics and the Iconography of Illness,' in *Graphic Medicine Manifesto*, ed. by MK Czerwiec and others (Pennsylvania: The Pennsylvania State University Press, 2015), pp. 115 - 42 (p. 129).

[60] Ian Williams, *The Bad Doctor* (Brighton: Myriad Editions, 2014) and *The Lady Doctor* (Brighton: Myriad Editions, 2019).

promotion of graphic illness narratives based solely on their instrumentalisation for the purposes of medicine. *Marbles* and *Lighter than my Shadow* could both easily be used to inform patients about bipolar and anorexia respectively and to provide doctors with models of care (and case studies of inappropriate interactions), but this is only one way of interacting with such texts. There has been relatively little critical engagement with comics about mental illness, despite their abundance.[61] The little scholarship that has analysed such narratives has often focussed on the therapeutic potential of drawing, and the concomitant healing supposedly implicit in creating a comic about mental illness and trauma.[62] Williams interviewed comics artists to ask whether their motivation for creating graphic narratives was therapeutic and whether they experienced catharsis in undertaking their work, with the answers varying from those who see their narrative as a purely artistic endeavour, to those who hoped for some therapeutic impact, to those who had not undertaken the project as a therapeutic endeavour, but nonetheless experienced some catharsis.[63] Whilst the relationship between graphic narrative and therapy is interesting in its own right, when this is the primary focus of criticism, the ensuing readings of texts are extremely limited.

Rather than hypothesising as to the therapeutic capacities or pedagogical applications of comics about mental illness, in this chapter I analyse the ways in which graphic memoirs exceed and disrupt dominant expectations of illness narratives. Reading *Marbles*, I argue that Forney capitalises upon the multiplicity, layering, and expansiveness integral to the comics form to reclaim her *DSM* diagnosis of bipolar and frame it as part of a wider, richer life

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[61] See Brick, *Depresso: or, How I Learned to Stop Worrying and Embrace Being Bonkers* (London: Knockabout, 2010), Daryl Cunningham, *Psychiatric Tales* (London: Blank Slate, 2010), Clem Martini and Oliver Martini, *Bitter Medicine: A Graphic Memoir of Mental Illness* (Ontario: Broadview Press, 2010), Rachel Lindsay, *RX: A Graphic Memoir* (New York: Grand Central Publishing, 2018).

[62] The only critical work currently published on *Lighter than my Shadow* make this argument, and whilst, as I will demonstrate, art is integral to Katie's recovery and sense of self, the analysis in this article is overly-simplistic. Sathyaraj Venkatesan and Anu Mary Peter, '"I Want to Live, I Want to Draw": The Poetics of Drawing and Graphic Medicine', *Journal of Creative Communications*, 13.2 (2018), 104-16. One exception to this trend is Elisabeth El Refaie, 'Looking on the Dark and Bright Side: Creative Metaphors of Depression in Two Graphic Memoirs', *a/b: Auto/Biography Studies*, 1.29 (2014), 149-74.

[63] Ian Williams, 'Autography as Auto-Therapy: Psychic Pain and the Graphic Memoir,' *Journal of Medical Humanities*, 32 (2011), 353-66.

narrative that exceeds diagnostic criteria. I analyse Forney's structural and stylistic choices to communicate episodes of mania and depression without having to use prose, thus avoiding diagnostic language. I also explore how mood is depicted on her avatars, emphasising the bodily symptoms of bipolar as well as linking to Price's bodymind. In my analysis of *Lighter than my Shadow*, I explore the entangled nature of Katie's history of anorexia and sexual violence. Bodymind is crucial to my analysis of Green's memoir because anorexia and assault are both psychological and physical experiences, and Green emphasises their interdependence through her drawings of different kinds of avatar. At the heart of this chapter is a recognition of both artists' reliance on the visual and the insufficiency of prose to convey the complexities of their experiences of mental illness and distress.

Energy and excess in *Marbles*

Marbles is about Forney's experiences of living with bipolar disorder and her reflections on what it means to be an artist with a diagnosis of mental illness. Over the course of the memoir she narrates her initial diagnosis; symptoms and moods; psychiatric appointments; struggles with drug compliance; and the impact of her illness on her social, sexual, and professional relationships. *Marbles* is also a memoir about the importance of drawing to Forney's identity and as a tool that captures and communicates emotional and psychological distress. After its publication, Forney received so many messages from people who connected with the memoir and found it a useful touchstone during their own episodes of mania and depression that she wrote another graphic narrative, *Rock Steady: Brilliant Advice from my Bipolar Life* (2018), filled with exercises, practical advice, and reassurance for people struggling with mood disorders.[64]

Analysing *Marbles* brings me nearly full circle to where this thesis started, with Kay Redfield Jamison's *An Unquiet Mind*. There are numerous similarities between the two

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[64] Ellen Forney, *Rock Steady: Brilliant Advice From my Bipolar Life* (Seattle: Fantagraphics Books, 2018).

memoirs. Both authors detail the fraught journey of trying to achieve and maintain stability whilst living with bipolar disorder; both talk about their fear of what the diagnosis means for their sense of self and their professions; both write about the importance of their relationships with their psychiatrist as well as family members and partners for emotional support; and both have similar trajectories in their conclusions that living with their diagnosis requires a state of ongoing negotiation.[65] Forney even explicitly refers to *An Unquiet Mind* and *Touched with Fire* – Jamison's study of manic-depression and creativity – in *Marbles* as a source of 'company' (p. 90).[66] Whilst there are many similarities between Jamison and Forney's illness narratives, there is one crucial and obvious difference: Forney's is graphic, and this is absolutely fundamental to how she communicates her experiences of being bipolar. In an interview with Paul Merton, Forney stated that she 'think[s] that comics, in general, […] are approachable in a way that text isn't,' and also argued that comics have a different 'emotional quality' and 'emotional communication' to written texts, which is particularly important when a story is about mood.[67] Rather than relying on passages of descriptive prose to try to capture the feelings that characterize mania and depression, Forney shows us. In this section, I will analyse the ways through which Forney capitalizes upon the emotional and embodied quality of comics in her depiction of her moods and her reflections on the importance of drawing as a tool to express them. I will demonstrate how the graphic medium provides Forney with ways of communicating the excitement, frenetic-ness, connectedness, and overwhelming nature of mania, as well as the numbness of episodes of depression, without having to rely on language, which is frequently diagnostic. Though not a counter-diagnostic narrative, *Marbles* nevertheless emphasises the complexity and multiplicity of Forney's experiences, and seeks to reframe her diagnosis as part of a wider and richer narrative than a *DSM* label can provide.

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[65] For more on these connections, see Bethany Mannon, 'Identity, Bipolar Disorder, and the problem of self-narration in Kay Redfield Jamison's *An Unquiet Mind* and Ellen Forney's *Marbles*', *Journal of Medical Humanities*, 3 (2018), 1-14.

[66] Ellen Forney, *Marbles: Mania, Depression, Michelangelo and Me* (London: Robinson, 2013).

[67] Merton, 'Immersion Therapy: The Millions Interviews Ellen Forney'.

Marbles reads like a collage that has been compiled from various sources and modes of representation to depict life with bipolar. In Chapter One I emphasised the impact of different documents coming together to build and disrupt Kaysen, Slater, and Washuta's illness narratives. Washuta in particular played with juxtaposing and assembling various modes of writing to get at her entwined experiences of mental illness and trauma, but all of her elements, while stylistically varied, were textual. *Marbles* too reads like an assemblage; however, here the juxtaposition of elements on the page is even more apparent because of comics' visual-verbal interplay. Forney not only layers perspectives and temporalities through text – in her use of speech and thought bubbles, quotes, and retrospective narrative asides – but also plays with the way in which these prose elements interact with her different modes of drawing. Forney interchanges between comics grids, splash and double truck pages;[68] she also reproduces photographs, sketches of other artists' work, drawings from her own sketchbooks, writing from her journals, and passages of texts ranging from the *DSM* to *The Bell Jar*. A far cry from the textual illness narratives typified by Arthur Frank and Anne Hunsaker Hawkins, *Marbles* is a text that bursts.

My analysis of *Marbles* builds on the work of Courtney Donovan, Lisa Diedrich, and Jodi Cressman. Donovan, arguing for the inclusion of graphic narratives in feminist discussions of health and medicine, emphasises the importance of embodiment in *Marbles*, recognising Ellen's body as a material site that expresses the emotions and physiological symptoms of her illness, and one that is routinely tested as part of the monitoring and regulation of its psychopharmaceutical treatments.[69] Lisa Diedrich, in her assessment of comics as a posthuman form, uses *Marbles* to illustrate the ways in which graphic narrative renders illness

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[68] The comics grid is a highly structured way of dividing the page between panels – usually square / rectangular - and gutters. A splash page is a whole page spread, and a double truck page is a double page spread.

[69] Courtney Donovan, 'Representation of Health, Embodiment, and Experience in Graphic Memoir', *Configurations*, 22.2 (2014), 237-53.

an assemblage, in the Deleuze and Guattarian sense of the term.[70] Cressman, though not explicitly drawing upon the language of assemblage, also analyses how Forney creates a collage narrative and the resulting ways in which meaning is stacked, rather than sequential, in *Marbles*; she then reads this narrative construction as a resistance to the terms of dominant models of illness narratives, which frequently propel the subject towards a resolution based on cure or recovery.[71] Like these scholars, my own reading of *Marbles* pays particular attention to embodiment and the collated structure of Forney's narrative. Emphasising the excess that characterises the memoir, I argue that Forney reclaims her diagnosis from the *DSM* by re-contextualising it as part of a rich life that exceeds diagnostic criteria.

Shortly before her 30th birthday Ellen is diagnosed with bipolar disorder. Like Kaysen and Washuta, Forney provides an annotated, and illustrated, version of her diagnosis. When Ellen acknowledges that both she and her mother have bipolar tendencies, but denies that she could have bipolar disorder, her psychiatrist, Karen, suggests: 'Let's take a look at the symptoms' (p. 15). Karen takes a large book off her shelf, which Ellen recognises as the *DSM*. The manual is foregrounded in the centre of the panel, held by Karen, with Ellen looking dubious in the background. Having worked for a few years in a short-term involuntary psychiatric unit, Forney tells us in the next panel, she is familiar with the volume. Standing next to Karen, arms crossed, Ellen looks over her shoulder whilst Karen points to and reads the criteria for a manic episode from the *DSM.* There are six panels, arranged in three tiers, on each of the following two pages. The panel on the left is a bordered square that contains a drawn close up of a page in the *DSM* listing the symptoms – one criterion per panel – and Karen's hand pointing to each. The panel on the right is an interlocking thought bubble relating to the criterion. On top of, or overlapping, each panel are text box captions containing retrospective commentary by Forney. For example, the first panel criterion is '(1) inflated self-

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[70] Lisa Diedrich, 'Comics and Graphic Narratives,' in *The Cambridge Companion to Posthuman Literature*, ed. by Bruce Clarke and Manuela Rossini (Cambridge: Cambridge University Press, 2016), 96-108.

[71] Jodi Cressman, 'Company, Counterbalance, and Closure in Ellen Forney's *Marbles*,' *Journal of Graphic Novels and Comics*, (2018), 1-14.

esteem or grandiosity', and a text box tells us 'I had to admit that one'. The thought bubble frame depicts a scene at a party with Madonna and Ellen, smiling, drinking, and exchanging 'banter.' Forney writes that she had had a 'sudden realization not long before, out of nowhere' that if she was at a party and Madonna was there, she 'wouldn't be intimidated at all!!' (p. 16).

Each tier goes through another criterion from the *DSM* for a manic episode. In response to decreased need for sleep, Forney writes that she 'hadn't really seen it as a problem' (p. 16) and draws herself bouncing awake, half naked, singing, and ready to seize the day. For more talkative than usual, or pressure to keep talking, the text box states 'I'd noticed this' and the thought bubble panel cuts to Ellen's face in profile, eyes wide, mouth gaping, bombarding someone with a stream of consciousness. The text takes up most of the panel, and the other person, drawn only as a cartoon face in profile, can only get out the words 'Um, I think–' (p. 16). In the bubble responding to the next criterion, 'flight of ideas, or subjective experience that thoughts are racing' Forney repeats the set-up of the previous panel, but this time her hair is wild and blends into an image of 'spinning wheels burning rubber,' there are multiple arrows emanating from her, even wider, mouth, and arrows and spirals tracing the connections between the various strands of her stream of consciousness; the cartoon interlocutor now looks bewildered and is silent. Ellen objects to the next symptom, 'distractability (i.e., attention too easily drawn to unimportant or irrelevant stimuli)'. This time the panel on the right cuts back to Ellen standing looking over Karen's shoulder, a speech bubble that crosses the gutter to overlap with the panel on the left declares '"Unimportant or irrelevant? That's subjective. Everything is relevant.' Whilst Karen replies that 'That's only one possible symptom,' a thought bubble coming from Ellen loops round to form the border of the other side of the panel and illustrates this criterion in process: Ellen goes from quoting 'one possible symptom' with a simplified icon of Karen's face to noticing a spot of light on the floor, wondering if the spot of light is a metaphor for trying to find clarity before noticing that her mind has wandered, and bringing herself back to the room with 'wait – pay attention'. Noticing this irony, the retrospective commentary, contained in the text box, simply states: 'HM'. On

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Figure 9: Forney's annotated diagnosis of bipolar disorder, pp. 16-17

the last panel of these two pages, responding to symptom number 6, ‘increase in goal-directed activity (either socially at work or school, or sexually),’ Ellen and Karen, one in each top corner of the frame, look down on a bubble containing a heart with an exaggeratedly flirty face, winking and grinning, declaring that Ellen is ‘sex positive 200%’ and thrives on being overcommitted; a text box in the bottom left states, in capitals ‘THESE WERE ALL DESCRBING ME!’ (p. 17). Finally, on the next page, Forney provides multiple humorous examples of her hypersexuality – from flirting with a wall, to instigating a spontaneous hook up with a shop owner who she had just met, and introducing a woman, who she had also just met, to ‘sapphic pleasures’ by candlelight (p. 18). The interchanging between the square panels in which Forney reproduces pages from the *DSM* and her thought bubbles show the process of experience, feeling, or encounter becoming symptoms, and interpreted as part of a diagnosis.

Forney’s identification with each of the criteria listed in the *DSM* culminate in a sudden realisation that she has bipolar disorder. This realisation takes the form of a splash page. At the top, Forney writes, ‘my own **brilliant, unique** personality was neatly outlined right there, in that inanimate stack of paper’ (p. 19, original emphasis). Below, taking up most of the page, is a head and shoulders illustration of Ellen as if in a mugshot, holding a placard with her *DSM* diagnosis and code ‘Bipolar 1 Disorder 296.4’.[72] In the negative space, Forney writes: ‘My personality reflected a DISORDER – […] – SHARED by a group of people,’ and describes the sensation with the similes that it felt like the sun sinking behind a cloud, or being covered by a heavy blanket like a parrot. These similes are literalised with small drawings of a cloud, and a blanket in the shape it would make covering a cage. Being told, and acknowledging, that attributes that Forney had identified as part of her personality could also be used to diagnose her with a mental illness is oppressive and suffocating, and this is cemented in the next page, another splash page, that compares the sensation to ‘a magic eye stereogram revealing a clear, irrefutable 3-D image’ ‘YOU ARE CRAZY’ (p. 20). Like Jamison, who found the term bipolar ‘strangely and powerfully offensive,’[73] and Washuta, who described the feeling of

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[72] 296 is the code for Bipolar 1 Disorder in the *DSM*, 296.4 indicates that Forney’s most recent episode at the time of diagnosis was manic.

[73] Jamison, *An Unquiet Mind*, p. 181.

receiving her *DSM* diagnosis as her brain transforming from 'swirls of dusty glitter' to 'gray matter' and being 'wrung like a sponge,'[74] Forney struggles with the feeling of being summarized by the *DSM* and its reductive language.[75]

Receiving a diagnosis forces Ellen to re-categorise and re-contextualize her moods as part of a disorder. Asked whether she can think of any other extended periods of ups or downs, Ellen starts remembering and listing other episodes of heightened and depressed moods, reflecting: 'Wow, I've never thought about it like this' (p. 21). The diagnosis also makes the reader rethink Ellen's moods. In chapter 1, before the moment of diagnosis analysed above, Ellen relays her excitement for her idea for a tattoo. Drawn on a double page spread, Forney illustrates the 'network' that suddenly 'lit up' in her head (pp. 6-7). The pages are a mind-map of ideas and connections that lead her to decide upon a full-back, water-themed tattoo by Kaz, one of her favourite cartoonists. The page has multiple large lightning bolts emanating from the onomatopoeic 'KRAK!!' written in bubble writing, below which are two, very large, wide-open eyes, and a smiling mouth. The page continues its noisiness with other onomatopoeic words, including 'gasp!' and 'dzzt!', and 'ping!', repeated around the page to simulate the sound of popcorn, to which Forney likens her ideas. Arrows form connections between ideas across the page deciding on the location, theme, and design of the tattoo, but also often just leading to exclamation marks, stars, spirals, and more arrows. Given that this episode comes before Ellen's diagnosis, the elevated mood in this spread is not necessarily attributed to mania and interpreted as a symptom, but simply seen as a bubbling and enthusiastic moment of creativity. However, after being taken through the *DSM*'s symptoms, this spread

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[74] Washuta, *My Body is a Book of Rules*, p. 140.

[75] Additionally, Forney has the particular anxiety as to what receiving a diagnosis does to her identity as an artist; she frequently asks herself to what extent her bipolar fuels her creativity, and, concomitantly, whether taking lithium will detract from her artistic practice. These questions are part of a wider exploration in *Marbles* about what it means to be an artist with a mental illness, belonging to, as Forney dubs it, "club VanGough".

unavoidably takes on a different set of associations and is retrospectively attributed to Forney's diagnosis.

By repeating the same stylistic details in this spread to narrate later manic episodes, Forney creates an iconography of mania. This means that the reader starts to recognise the symptoms of Ellen's moods, and predict when she is heading towards a manic episode without having to be explicitly told. For example, at the start of chapter 3 Forney indicates that a manic episode is imminent. Opening in a psychiatry appointment, the page is structured by six panels arranged in three tiers. In response to Karen asking 'How's work?' Ellen replies: 'Great! I guess. I'm so busy!' (p. 49). The next panel cuts to a head and shoulders view of Ellen reading aloud a list of her commitments with a speech bubble in the bottom left corner, coming from the border stating 'That's a lot'. On the next tier, the panel cuts to a close up of Forney's head, with larger eyes and accentuated eyelashes. The text is packed around her head with ellipses and stars interrupting it. The line of text then cuts across the border of the panel into the next one where it spirals around an even larger, and more abstract, image of Ellen's face. Unlike the other frames on the page, this one does not have a border, instead it has spirals and dashes in each corner. The lines depicting Ellen's face are more jagged, her hair is less neat, and her features are alarmingly exaggerated. The energy level of this tier is much higher as Ellen gets caught up in the excitement of her different projects and starts talking tangentially about being a queer role model and the need for more liberal identity politics. In the final tier of the page, the scene returns to the room, with Karen and Ellen sitting across from each other in profile. As they talk about the logistics of fulfilling these projects, a smaller version of the face from the previous panel, even more garish and with multiple blank speech bubbles emanating from it, whizzes away at the top of a frame like a deflating balloon, accompanied by the sound 'konk!' as it hits the border of the panel. By the last panel on the frame there is only one star and one spiral remaining by Ellen's head as she dismisses Karen's concerns about her income. While it seems that Karen has grounded Ellen on this occasion, Forney has signalled the precariousness of her moods. That the reader can recognise when Ellen is heading towards mania, even when she does not realise it herself, establishes an intricate power dynamic between Ellen, Forney, and the reader. Forney manipulation of the comics form to craft a sense of the inevitability of the oncoming manic episode, of which Ellen is blissfully unaware, is much more sophisticated than the obvious prose equivalent “little did I know….”.

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Figure 10: Starting to signal mania, p. 49

Indeed, the next page is a double page spread with a caption in the top left corner stating ‘A Week Later…’ Here Ellen’s avatar stretches impossibly over the pages, her arms and legs are elastic, as she is drawn in mid stride on one of her ‘energy-burning walks’ (pp. 50-51). A huge lightbulb coming from Ellen’s head tells us that she has had ‘another explosive, electric idea:’ to have a joint book release and 30th birthday party. As with the double page spread analysed earlier, these pages are both expansive and densely populated by images, text, arrows, and exclamation marks, with different handwriting changing between capitals, non-capitals, and bubble font. Again there is a tremendous sense of energy that the pages struggle to contain, and, turning the page, the tone of this energy changes. The next pages are another double spread, but here the effect is vertiginous (pp. 52-53). A terrifying cartoon of Ellen’s face, recognisable chiefly by her characteristic hair, is drawn in the centre of the left-hand page. Her eyes, normally drawn as black dots, are wide, with hollow pupils, with dashes of various lengths emanating from them; she has no nose, and her mouth is drawn in a grin that borders on a grimace. Stars and squiggles cover and emanate from her forehead. Sprouting from this head are multiple cartoon arms, with jagged fingers that reach across the pages and section it off in a kind of grid. In each of the panels created by these arms, Forney writes and draws details and scenes depicting the planning of her party – from her outfit, to the venue, entertainment, decorations, and all of her friends helping her organise the event. One of these panels shows a friend carrying lots of balloons, next to him is Ellen, grinning, drawn with six arms (like those dividing the page) reaching and gesticulating in different directions, and five legs. Surrounding this image is the text: ‘Okay now we need to hand I mean hang the crepe paper & set up the birthday cake table & spin art table & I don’t know where to start! I’m excited!! Aiii!!!’ Here text and image amplify each other to convey Ellen stumbling over her own excitement, both stimulated and overwhelmed by the multiple tasks to complete.

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Figure 12: The enthusiasm and energy of mania, pp. 50-51

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Figure 11: Mania becoming overwhelming, pp. 52-53

Ellen’s manic episodes are characterised by distorted avatars and an excess of information and lines on the page. During manic episodes, Ellen’s body is stretched to dominate the page, her features are accentuated – eyes normally drawn as dots become wide or spirals, her mouth, normally a singular line, gapes and grimaces – and her hair, normally coiffed, becomes dishevelled. By manipulating Ellen’s avatars in these ways, Forney mobilises Price’s bodymind: she simultaneously communicates mania via the body and emphasises the fact that mania is a bodily experience. Forney repeatedly uses double page spreads to communicate the expansiveness of these episodes. However, the pages are dense and busy as Forney fills this extra space with images, speech, anecdotes, and narrative. This, coupled with the stars, spirals, lightning bolts, squiggles, exclamation marks, and onomatopoeia that also come to signify manic episodes, result in pages that bombard the reader. In contrast to the regular structure of pages divided by grids – for example those containing Ellen’s psychiatry appointments – these double page spreads are overwhelming because everything happens simultaneously. Rather than being guided sequentially through the tiered panels, these spreads force the reader to negotiate the pages in their own way, jumping from one image to another, and back again. The synchronic structure of these pages enacts Ellen’s manic enthusiasm and compulsion to pursue every idea she has, when she has it (p. 54). Furthermore, the excess of these pages communicates the energy, stimulation, and flood of ideas that characterises Forney’s mania while simultaneously showing Forney living with mania. By establishing structures and styles that the reader identifies as signalling manic episodes, Forney conveys the dizziness of mania without having to rely on the diagnostic language of the *DSM*, which she found so reductive.

The style in which Forney draws mania is, appropriately, oppositional to how she draws depression. A few weeks after the party Ellen’s mood crashes and she calls Karen in the middle of the night in a state of panic (p. 69). With jagged borders, and filled with scratchy black lines, these panels depict Ellen’s face, anxious, with a phone clutched to her ear. The words ‘crisis’ and ‘emergency’ are repeated and emphasised, and in the adjacent panel, Ellen’s eyes are at the bottom of the frame, wide in panic, surrounded by worry lines, above is a bubble filled with rats with pointed teeth scrabbling on top of each other and biting each other. At this point Ellen accepts a prescription of lithium, which she had been resisting, and puts her faith in her psychiatrist. To illustrate the episode of depression that follows, Forney arranges 14 simple line drawings over 5 tiers on a single page. These small, minimal, quiet drawings depict a sequence in which a figure slowly gets out of bed, wraps a blanket around herself, moves to the sofa, and lies back down (p. 77).[76] The repetition across the images communicates the lethargy and overwhelming exertion it takes simply to move from bed to sofa: Forney uses six images to depict the figure leaning up in bed and looking at the door. The customary exuberance of Forney's drawings is missing; instead these images have been stripped back to the least detail needed to communicate the sequence. The figure, when visible, is a simple outline, which lacks any distinguishing feature. This outline is frequently swallowed by the blanket in which she is wrapped, depersonalising her, with the result that, as Diedrich notes, the depressed subject 'begins and ends in formlessness'.[77] The bodymind of depression is very different to that of mania described above. The emptiness of these drawings is exacerbated by the lack of text on the page. The other pages in the memoir are filled with prose in combinations of thought and speech bubbles, quotes and commentary, making the lack of text in this sequence even more noticeable. If Ellen's mania is characterized in part by flights of ideas and a pressure to keep talking, the opposite is true of her depression. The figure on this page barely has the energy to get out of bed, let alone articulate her feelings. Depression here is numb, monotonous, repetitive, heavy, and characterized by absence. Visually, the contrast between this 'hieroglyphic sequence'[78] and the expansiveness of the bursting manic double page spreads could not be starker.

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[76] I continue to use she/her pronouns to describe this figure as it is clear from the memoir that the figure is Ellen. However, in isolation, they/them would be more appropriate as there are no distinguishing features.

[77] Diedrich, *Comics and Graphic Narrative*, p. 103

[78] Ibid., p. 102.

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Figure 13: Depicting depression, p. 77

To further communicate the emotions dominating her depressive episodes, Forney includes reproductions of sketches she drew at the time. Like the photocopies in *Girl, Interrupted*, the Instant Message transcription in *My Body is a Book of Rules*, Stuart's drawings and handwriting in his diary, and Henry's artwork, these provide a different kind of documentation of Forney's moods from the time at which she was experiencing them. The first sketch comes immediately after the panels in which she calls Karen in the middle of her night. Drawn on lined paper, the border of the photocopied page indicates that it has been ripped out of a pad. The sketch depicts Ellen struggling to cling onto the edge of a cliff, and is accompanied by the caption: 'I was slipping down and there was nothing I could hold on to' (p. 70). Ellen's desperation is conveyed through the scratch lines left on the surface of the cliff made by her frantic attempts to hold on, her fingers clawing at the edge, her large, wide eyes, with hollow pupils, surrounded by worry lines; her mouth open in a scream; and her dishevelled hair. The line work, done in pen, is rough, quick, and jagged, to the extent that her body loses definition and blends into the cliff. In contrast, the face has been worked into repeatedly to emphasise the expression of terror. McCloud emphasises the expressive potential of different lines and their ability to convey emotion based on their shape, direction, and character.[79] The sketchy immediacy of this drawing's lines contrasts with the smooth, thick, decisive lines with which Forney inks her retrospective narrative. Such a stylistic difference reminds us how crafted and drafted graphic narratives are. The spontaneity and directness of the line-work of the original drawing comes across as more intimate and vulnerable, and by including a reproduction of an original sketch from the time of her depressive episode, Forney instigates another layer of opening up with her reader.

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[79] McCloud pp. 124-27.

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Figure 14: A sketch from during a depressive episode, p. 70

Drawing becomes an integral coping mechanism for Ellen during depressive episodes. Whilst she tries some Cognitive Behavioural Therapy techniques, and finds company through reading others' memoirs of mental illness, it is really in her sketchbook, Forney writes, that she could 'face [her] emotional demons in a wholly personal way' (p. 92). Although she rarely has the energy to draw, Ellen starts carrying her sketchbook with her, and describes it as 'a combination of carrying a teddy bear & carrying a can of mace,' as the 'drawings both scared [her] & gave [her] comfort' (p. 92). This text is accompanied by an abstract image of Ellen crying and drawing. Zigzags and crosses emanate from her head, and a lightning bolt goes directly from the centre of her brain onto the page of the sketchbook in front of her, on which she is also drawing zigzags. Drawing is presented as a means for Ellen to externalize and contain her feelings, and acts as a tool for expression, reflection, and self-observation. 'Inert on a piece of paper,' Forney writes, 'the demons were more handleable' (p. 98). Diedrich terms this visual duplication of Ellen's inner experiences (Forney's drawing of her brain and her drawing-of-her-drawing-of-her-brain) drawing *en abyme.*[80] *Mise en abyme* (literally 'put into the abyss') emphasises the ways in which representation is staged and mediated in literary and visual texts by bringing attention to processes of self-reflection; formally it involves placing a copy of an image within itself, for example a picture of someone holding a picture depicting the same scene, or someone caught between two mirrors so that the reflections continue infinitely.[81] The doubling operation integral to Diedrich's drawing en abyme denotes representations of the self-becoming and/or un-becoming self; the subject here is not something one is, but is something one does, or becomes, through drawing.

Forney further develops her engagement with the performativity of drawing through illustrations of mirror scenes. Often after seeing Karen, scared at the prospect of not having

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[80] Lisa Diedrich, 'Graphic Medicine en abyme: drawing sketching-as-therapy in Ellen Forney's "Marbles"', *The Polyphony*, (24 January 2019), < https://thepolyphony.org/2019/01/24/graphic-medicine-en-abyme-drawing-sketching-as-therapy-in-ellen-forneys-marbles/> [accessed 4/2/2019].

[81] See Michael Chaney, 'Terrors of the Mirror and "Mise en Abyme" of Graphic Novel Autobiography,' *College Literature* 38.3 (2011) 21-44.

access to the safe space of the therapy session for a while, Ellen runs to the toilets and cries. Afterwards, she takes out her sketchbook, looks at herself in the mirror, and draws. In the narrative, Forney shows us Ellen crying, looking at her reflection in the bathroom mirror, clasping her sketchbook. In the panel below the scene zooms out to show Ellen standing in front of the bathroom mirror drawing herself. This meta-moment is another instance of Diedrich's drawing *en abyme*. This mirror scene episode provides a reflexive (as well as reflected) moment in which Forney self-consciously engages with the processes of drawing and becoming drawn. This internal duplication is, in turn, extended even further as Forney subsequently includes a reproduction of one of her mirror self-portraits, taken from her sketchbook, with its original caption 'crying in the bathroom' (p. 100), within the pages of the memoir.

In the introduction to this chapter I discussed how drawing autobiographical avatars engages the author with a sense of their own physicality, and its embeddedness to their identity. Analysing the frequent use of mirror scenes in comics, El Refaie argues that when 'mirrors are used in self-portraits, they can form a potent visual metaphor for the ambiguity involved in seeing something that both is and is not "me", as well as our inability to pin down our fluctuating sense of self'.[82] Ellen's fluctuating sense of self is emphasised in the 'jarring' contrast between how she imagines herself to be/look and the reflection that confronts her in the mirror: 'I looked so small, and so, human – a sad human – not like the horrible monster I half-expected to see' (p. 98). By drawing her reflection, Ellen gains some reassurance of her sense of self; Forney writes: 'in my sketchbook, I'd trace the familiar lines of my face, & I'd calm down & come back into myself' (p. 98). Relative to her changeable moods, Ellen's body is comfortingly stable, and she can take solace in the solidity of her physicality. In the next section I will show how impossible this is for Green, whose relationship with mirrors is fraught, even symptomatic, and whose changing moods and body both signify her illness.

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[82] El Refaie, *Autobiographical Comics*, p. 66

Forney's depictions of Ellen drawing her reflection stage a series of layered encounters with the self. Through these meta-moments of drawing en abyme Forney reflects on what it means to write and draw the self, which is, of course, the task of the graphic memoir. Throughout *Marbles* there is a tension between the writer/narrator, Forney, and the subject, Ellen. While these all refer to the same person, they are separated by different temporalities: Ellen is drawn as going through the experiences while Forney retrospectively narrates them. This is similar to the way in which Kaysen of the 1990s looked back on and characterised the Kaysen of the 1960s in *Girl, Interrupted*, but, as I wrote in the introduction to this chapter, the visual nature of comics makes the distinction between subject and narrator more obvious. This separation between Ellen and Forney is resolved in the conclusion of *Marbles* in which Forney draws a different kind of encounter: between her past and present (at the time of drawing) self. Replicating the structure that she normally uses to draw psychiatric appointments, Forney draws two avatars of herself ('future self' and 'younger self') sat across from each other in conversation. 'Future self', the older narrator Forney, sits on the left, where Karen normally sits, across from a younger Ellen. Forney reassures Ellen, tells her that she does need to take medication (which Ellen, manic, denies), tells her to 'hang in here' while Ellen sobs in an episode of depression, and reaches out to comfort her and hold her hand (pp. 234-35). As the panels progress, Ellen starts to look more and more like Forney. To Ellen's question 'what is your life like?' Forney replies 'it's different, but it's not really that different […] I'm still **you**'. Here the panels cut to Forney brushing her teeth in the bathroom mirror, a speech bubble coming from off the panel asks, 'But I mean, things are good? You're okay?' to which Forney, her reflection looking up towards the thought bubble, replies 'Well, I can't say things are always easy, but they're good! And yeah- -', turning the page, the final panel of the memoir is Forney's reflection framed in the bathroom mirror accompanied by the text, 'I'm okay!' (p. 237). In this final panel, Ellen and Forney have caught up with each other and merged to become one reflection, half-smiling out at the reader. *Marbles* ends on a positive assertion of okay-ness, which, while celebratory, refrains from being triumphant.

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Figure 16: Encounter between Forney's 'future self' and 'younger self', pp. 234-35

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Figure 15: Ellen and Forney become one, p. 236

Anorexia, assault, and the bodymind in *Lighter than my Shadow*

Lighter than my Shadow is a coming-of-age narrative about the difficulties of Katie's relationship with her body, and the implications for her mental health. Set in the UK, it traces Katie's life from childhood to young adulthood, depicting the onset of puberty, life at secondary school and then moving to university alongside the development of anorexia, its impact on Katie's relationships with family and friends, and her varied interactions with medical professionals. It is also a narrative about the sexual abuse perpetrated by her therapist. As with the other memoirs in the thesis, *Lighter than my Shadow* disrupts a simplified, linear conception of recovery and overcoming; in fact, the overwhelming burden to "be recovered" is integral to Katie's distress and relapse. As I wrote at the very beginning of the thesis, on the website that advertises the memoir, Green addresses a letter to the reader in which she writes: 'I wished for an instruction manual, and that's what I hoped to provide. But as my own recovery unfolded and took turns I could never have anticipated I learned why such a book could not exist'.[83] Katie's entangled experiences of illness and trauma vex her relationship to recovery and mean that such a text is inaccessible to Green. As such, Green's graphic memoir speaks back to Slater's *Lying* and *Welcome to my Country*, Washuta's *My Body is a Book of Rules*, and Masters' *Stuart*, all of which traced the enmeshment of psychological distress, mental illness, and histories of sexual abuse. As with my analysis of Washuta's memoir, I will argue that life writing acts as a vehicle for Green to work through and witness her illness, assaults, and their intersections. However, my analysis will emphasise how the dynamics of working through and witnessing are altered by Green's emphasis on visual, rather than verbal, storytelling. Green's prioritisation of the visual over the linguistic, I will argue, illustrates the insufficiency of language to convey the complexities of illness and trauma, and emphasises the bodily, as well as psychological, dimensions of those experiences.

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[83] Katie Green, 'Dear Reader', *Lighter than my Shadow*, (May 2017), <https://lighterthanmyshadow.com/dear-reader/> [accessed 25/10/18].

Anorexia and sexual assault are both psychological and physical experiences, and Green's comics create a space in which the imbrications of mental illness and sexual violence, body and mind can be explored without being reductive. Price's concept of the bodymind, outlined in the introduction to this chapter, is invaluable here to think through the reciprocity between the mental and physical; as Emily Troscianko has noted:

> Nowhere is the impossibility of separating mind from body clearer than in an eating disorder (ED): both sicken in a reciprocal back-and-forth, and both recover that way too. Typically classified as 'mental illnesses', EDs are an excellent example of how the psychological and the physical have to be understood as interacting parts of the same system.[84]

Additionally, Timothy Brewton argues that 'issues of psychiatric comorbidity and trauma history are unavoidable for clinicians who diagnose and treat patients with eating disorders'.[85] Brewton continues that it is extremely rare that patients with eating disorders are 'individuals with *just* eating disorders', but are more likely to also experience other conditions or symptoms including anxiety, substance use, and personality disorders. Given that Price's conceptualisation of the bodymind was influenced by her reading of literature on trauma, it is an even more appropriate tool with which to analyse *Lighter than my Shadow*.[86]

In the introduction to this thesis I discussed the intricacies of the relationships between (mental) illness, trauma, and disability. In particular, I highlighted instances of scholarship that call for more porous and reciprocal criticism between trauma studies and disability studies; including work by James Berger, Valerie Raoul, Daniel Morrison and Monica Casper, Alison Kafer, Tobin Siebers, and Margaret Rose Torrell.[87] My analysis of Green's

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[84] Emily T Troscianko, 'Feedback in Reading and Disordered Eating,' in *Cognitive Literary Science: Dialogues between Literature and Cognition*, ed by. Michael Burke and Emily T Troscianko (Oxford: Oxford University Press, 2017), pp. 169-95 (p. 169).

[85] Timothy Brewton, 'Eating Disorders, Trauma, and Comorbidity: Focus on PTSD', *Eating Disorders*, 15.4 (2007), 285-307 (285).

[86] See Babette Rothschild, *The Body Remembers: the psychophysiology of trauma and trauma treatment* (New York: Norton, 2000).

[87] James Berger, 'Trauma without Disability, Disability without Trauma: A Disciplinary Divide', *JAC: A Journal of Rhetorics, Culture and Politics*, 24.3 (2004), 563-82; Valerie Raoul, 'Making Sense of Disease, Disability, and Trauma: Normative and Disruptive Stories', in *Unfitting Stories: Narrative approaches to*

graphic memoir is informed by this body of scholarship, particularly Torrell's analysis of Kenny Fries' *Body, Remember* (1997) – a prose memoir about congenital disability and sexual abuse – which recognises the interconnectedness of disability and trauma, and their concomitant physical and psychological dimensions. Whilst I recognise anorexia's uncomfortable position as an illness/disability, Schalk's recent investigation of bodyminds posits a broader definition of disability that applies well to Green's memoir. Schalk reads a character as disabled if:

> the character experiences their bodymind as different from others and that difference cannot be better interpreted as gendered, racial, or another type of difference; if that character's bodymind is interpreted from a medical or psychological perspective in the text as nonnormative and in need of treatment or cure; and if a character's bodymind variation is considered nonnormative or deviant by the text's fictional society at large […] within this wide definition of disability, in my work, disease and illness are included, particularly when the disease or illness has extended or permanent effects on the character.[88]

While the first part of Schalk's definition feels somewhat stilted, her emphasis on medical designations of nonnormativity and deviance, and the subsequent space this creates for thinking through illness and/as disability, provides me with a way of grappling with Katie's experiences in *Lighter than my Shadow.* My analysis of Green's memoir, mobilizing the concept of bodymind, builds on these scholars' discussions of the complex messiness surrounding the boundaries of illness, pain, trauma, loss, impairment, and disability, and extends them by introducing the graphic form into the equation.[89]

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disease, disability, and trauma, ed. Valerie Roaul et al (Waterloo: Wilfrid Laurier University Press, 2007), pp. 3-11; Daniel Morrison and Monica Casper. "Intersections of Disability Studies and Critical Trauma Studies: A Provocation." *DSQ: Disability Studies Quarterly,* 32.2 (2012), <http://dx.doi.org/10.18061/dsq.v32i2.3189>; Alison Kafer, 'Un/Safe Disclosures: Scenes of Disability and Trauma', *Journal of Literary and Cultural Disability Studies*, 10.1 (2016) 1-20; Tobin Siebers, *Disability Aesthetics* (Ann Arbour: University of Michigan Press, 2010); Margaret Rose Torrell, 'Interactions: Disability, Trauma, and the Autobiography', *Life Writing*, 13.1 (2016) 87-103.

[88] p. 28

[89] I am aware that it is potentially contentious to position *Lighter than my Shadow* amongst this scholarship because of the ambivalence of anorexia's status as a disability; see, for instance, Stephanie Tierney, 'A Reluctance to be Defined "Disabled" How Can the Social Model of Disability Enhance Understanding of Anorexia?', *Disability & Society*, 16.5 (2001), 749-64. However, the terms of Schalk's definition of disability – particularly being interpreted as nonnormative by a medical / psychological perspective, being considered deviant by society, and the illness having permanent effects on the character – fit so well with the portrayal of anorexia in Green's memoir and provide a productive framework with which to analyse Katie's experiences.

As I emphasised in the introduction to this chapter, comics is a form of 'textuality that takes the body seriously'.[90] Extending Couser's concepts of autosomatography and somatography – life writing that narrates 'what it's like to have or to *be*, to live in or *as*, a particular body,' or the experience of 'living *with*, loving, or intimately knowing someone' with an 'odd or anomalous' body[91] – DeFalco coined the phrase 'graphic somatography' to discuss the subgenre of comics that 'depict experiences of vulnerability caused by illness or impairment, repeatedly drawing attention to the fragility of embodiment and the inevitability of interdependence and care'.[92] The experiences of vulnerability caused by illness, impairment, and trauma, and Katie's subsequently fragile embodiment, are at the heart of *Lighter than my Shadow*. Green emphasises bodily processes in her narrative, particularly eating, walking, attempted purging, self-injury, menstruation, and masturbation, as well as monitoring the impact of anorexia on Katie's body. Bodies further dominate the pages of *Lighter than my Shadow* as Green also draws the numerous bodies that Katie feels she has, imagines herself as occupying, and remembers having had. Katie's sense of embodiment is then made even more fraught because of her experiences of abuse, and Green further emphasises her vulnerability by explicitly displaying the violence committed on Katie's body, and the visceral nature of her flashbacks.

The process of pictorial embodiment described by El Refaie, whereby an artist has to engage with their physicality and its impact on their identity as they draw their avatars, is troubled in *Lighter than my Shadow* as, in drawing Katie's anorexic avatars, Green also has to engage with the impact of illness on her body. As the narrative progresses, Green shows in detail the impact of anorexia on Katie's body. After Katie increases restricting her food, Green starts drawing in her collar bones (pp. 112-13). When Katie undresses, we see that her ribs,

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[90] Chute, *Graphic Women*, p. 4.

[91] G. Thomas Couser, *Signifying Bodies: Disability in Contemporary Life Writing* (Ann Arbor: University of Michigan, 2009), p. 2.

[92] DeFalco, p. 224.

vertebrae, and hip bones protrude (p. 118, p. 121). Standing in the shower Katie runs her hand through her hair and is confused when it falls out (p. 121). Green frequently draws Katie undressing or naked in this section of the memoir in order to emphasise the changes to Katie's body that are taking place, and this exacerbates the sense of her embodied vulnerability. In a wordless sequence, structured by the comics grid, Green ticks off the symptoms of anorexia visible on Katie's body: she looks in the mirror, brushes her hair, which again falls out, inspects her arms, which have become hairy, lifts up her shirt to look at her stomach in the mirror,

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Figure 17: Sequence depicting multiple symptoms of anorexia on Katie's avatars, p. 136

which has also grown lanugo,[93] and feels her protruding ribs and collarbones, before curling up on her bed to sleep (pp. 136-37).

Williams writes that ‘in graphic works the author constructs a visual avatar that represents his or her own ailing body and proceeds to show, as well as tell, the sequelae generated by the illness’.[94] Katie’s avatars certainly record the impact of anorexia; however Green never writes descriptions of Katie’s body. Instead, she allows us to witness visually the progression of the illness as it develops, and leaves it to the reader to interpret the extent of anorexia. In so doing, Green places the reader in a similar position to Katie’s parents, who witness the deterioration of her body. After the sequence of symptoms listed above, Katie’s father creeps into her room and sits on the end of the bed crying (p. 137). In another scene, at the breakfast table, Katie’s parents encourage her to eat more food, but Katie protests that she has had plenty. When her mum starts to say ‘You look…’ Katie interrupts her, shouting ‘I’m FINE’ and storms out of the room (pp. 122-23). Green creates layers of tension between the multiple images of Katie’s frail, emaciated avatar, her protests that she is fine, and her parents’ worried expressions. Furthermore, by interrupting her mum, Katie prevents description of her body. This means that the impact of anorexia on her appearance is left hanging unsaid in the ellipsis and allows multiple possible endings of the statement to coexist. By preventing descriptions of Katie’s body and by drawing, rather than naming, her symptoms, anorexia is allowed to remain the complex entity it is; something far in excess and more complicated than ‘you look too thin’ or ‘you look ill’.

Lighter than my Shadow is striking for its minimal use of text, particularly given the length of the memoir (507 pages). Katie’s resistance to description in the encounter above is in keeping with Green’s reluctance to communicate the effects of her illness, and later trauma, in

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[93] Downy hair is a symptom of anorexia.

[94] Ian Williams, ‘Graphic medicine: The portrayal of illness in underground and autobiographical comics,’ in *Medicine, Health, and the Arts: Approaches to the Medical Humanities* ed. by Victoria Bates and others (London: Routledge, 2014), pp. 64-84.

prose. Instead of describing Katie’s emotions textually, Green represents Katie’s bodymind by drawing shadows. The importance of the shadow is signalled by the memoir’s title. *Lighter than my Shadow* carries the double connotations of weight as well as emphasising light and dark. Shadows, it is worth highlighting, exist in relation to bodies and distort their size and shape. Dependent on the presence of a body and the concomitant absence of light, they consequently encapsulate the play between presence and absence that is integral to the comics form. To become lighter than one’s shadow, in either sense of the term, is obviously impossible, and this captures the inexhaustible drive behind anorexia. Throughout the narrative, Green draws patches of black scribbled lines, which take different forms and are mobilized for numerous purposes: as dark clouds over Katie’s head that grow as she becomes increasingly ill; to literally foreshadow events; to depict loss of consciousness; to indicate traumatic flashbacks; as borders for panels and replacement gutters; as speech and thought bubbles; and as backgrounds. Never contained within an outline, the shadow leaks and spreads, frequently breaking across frames and often engulfing Katie’s avatars. Given the multiplicity of the shadow’s forms and uses, it is, appropriately, difficult to pin down what it means. Indeed, the shadow does not represent any single concrete thing. Although the shadow gives the illness a presence on the page, it would be an oversimplification to argue that it is the embodiment of anorexia. Instead, it is an ominous, amorphous presence that indicates the distress, confusion, disgust, upset, pain, and anger that accompany Katie’s experiences of anorexia and abuse. The scribbles’ presence, prevalence, size, and density indicate the level of distress that Katie is experiencing – both in terms of underlying, ongoing upset, and active outbursts of emotion.

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Lighter *than my Shadow* opens with a drawing of Katie, facing away from the reader, standing on weighing scales, with the shadow above her head. On the following double page spread, Katie is drawn again on the scales, this time facing towards us, and the shadow has expanded around her to take up most of the two pages; inside the shadow are smaller, pale drawings of her naked emaciated body, tumbling, curled up, and in bed with a nasogastric tube (pp. 2-3). The shadow continues over the next two pages, containing multiple images of Katie's avatar, curled up and getting progressively smaller until she is an indefinite, tiny blob. Underneath this ribbon of black scribble, sits an avatar of the adult artist Green, at her desk, pen poised over a blank sheet of paper, looking up at the black band and the bodies contained within it (pp. 4-5).[95] Subsequently, the scribbles take the form of a tornado, the point of which goes into Green’s pen and, on the following page, the black scribbled shadow is now contained on the sheet of paper on which Green is drawing (p. 7); the next page of the memoir is blank, except for a small dark scribble near the centre. Like the replication of the zigzags in Ellen’s brain on the page on which she’s drawing in *Marbles*, this sequence is an example of drawing en abyme. Forney wrote that sometimes she ‘just let the images pour out of [her] pen’.[96] Green’s image of the tornado of shadow being channelled through her pen onto the page visualises a similar kind of pouring of emotion and situates drawing as a way of processing, filtering, transmitting and containing her memories of illness and abuse. The duplication of Green drawing her avatar about to draw emphasises the materiality of the text and the processes behind its construction from the outset. Furthermore, opening with a sequence in which an avatar of Green-the-artist remembers and watches avatars of Katie’s ill body

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Figure 22: Green remembering and witnessing Katie's illness, pp. 4-5

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[95] I refer to this avatars of the adult artist as Green to distinguish her from the child Katie.

[96] Forney, *Marbles*, p. 99.

establishes drawing as an act of witnessing and mode of working through. As was the case with Washuta's *My Body is a Book of Rules*, Green calls attention to the work that went into the production of the narrative, as well as the labour that the narrative performs.

The shadow's flexibility and capaciousness makes it the ideal substitute for text. Instead of having to find the exact words to describe the chaos of anorexia and abuse, and imposing description on these experiences, these scribbled and scrawling tight black lines convey the depth of these emotions and memories without containing them, and simultaneously indicate the difficulty of articulation. The shadow's relationship to text is explicitly manifested in two instances. When Katie is bullied on her way to school, the bullies' taunts are repeated in jagged handwriting, scrawled across the page in lines of text that, in subsequent frames, literally come unwritten as they break down into shadow at the bottom of the panels (pp. 52-3). Later in the memoir a dietician asks Katie to keep a journal of the food she eats and her feelings after meals. Writing in her journal, the words 'FAT,' 'HATE,' and 'disgusting' are repeated, both on the pages of the notebook, and flying off them, condensing and being absorbed into the shadow (pp. 173, 175). In both instances there is a transition in Green's lines from handwriting to scrawl to scribble as the words condense into a solid mass. The dense, tight, tangled texture of the shadow indicates the weight of feeling behind the words in a way that their neatly written form does not convey. The shadow, then, not only symbolises the entangled pain, confusion, distress, and disgust that Katie feels, but also indicates the impossibility and ineffectuality of translating those emotions into prose. Furthermore, the texture and consistency of the shadow builds upon my analysis of the bodymind when we consider the physical process of drawing those tight scribbled lines. Deciding upon the most appropriate words and writing them requires

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Figure 23: Words becoming shadow, p. 175

decisiveness and precision, as do Green’s meticulous illustrations. In contrast, there is no pressure for the shadow to be “accurate” or “correct” and so there is less of a barrier between the brain that feels and remembers, and the hand that draws.

The ways in which the shadow interacts with Katie’s avatars conveys the impact of anorexia on her bodymind. Katie first starts restricting her food as a Lenten resolution in which she gives up ‘all junk food’ (p. 93) and eating between meals. At the end of Lent she and her friends celebrate ceremoniously with a feast, but as Katie bites into a chocolate bar, the shadow appears over her head (p. 99). In a series of moment-to-moment panel transitions Katie goes from happily unwrapping the chocolate and lifting it to her lips, to taking a bite, chewing, swallowing, and looking confused and glum; the shadow-cloud gets larger and denser as the sequence unfolds. Asked whether she is okay, Katie replies ‘I don’t think I like the taste any more’ (p. 99). On the next page, however, Green cuts to Katie sitting, hunched over on her bed, with the caption ‘But it wasn’t the taste, it was the feeling’ (p. 100); these are the only words on the double page spread. Katie lies on her bed, with the black cloud overhead, clutching at her hip. She then rolls onto her side, grimacing, and the cloud expands to hang over her whole body. The next page is divided into three horizontal panels. Katie’s body now floats inside the scribbled shadow, still clutching at her hip, with her other hand on her inflated, pregnant-looking, stomach. On the next panel down, Katie draws dotted lines around her swollen stomach and enlarged bottom, and, on the final panel, she uses a cleaver to start cutting through the demarcated area on her bottom (p. 101). The first panel on the next page switches back to Katie lying on the bed, with the cloud overhead, crying.

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Figure 24: The shadow and bodymind avatars, pp. 100-01

That Katie uses a cleaver is significant. A scalpel, combined with the dotted lines drawn on her body, would introduce associations of surgical precision, whereas a cleaver, with its connotations of butchery, introduces an atomised view of the body in which parts are transformed into different cuts of meat. Rather than being thought of holistically, the body is itemised and fragmented, with Katie isolating and demarcating specific areas: stomach, thighs, bottom etc. This shift in Katie's relationship with her body is emphasised later on when, looking in the mirror, Green only draws zoomed in images of Katie's hands clutching at her hips and stomach in the reflection, instead of her whole body. This visual metaphor amplifies the captions, which state 'I couldn't see my whole body in the mirror,' and 'I only saw parts of myself. The parts I hated' (p. 118). Furthermore, the transformation from body to cut of meat via butchery suggests that the body is something to be portioned out, carved up, and potentially consumed. The avatars of Katie engulfed by shadow cutting herself are visual examples of Price's bodymind. They are not physical, situated avatars of Katie's material body, but imagined avatars on which Katie projects, and Green draws, her distress.

Green returns to images of self-injury in another double-page spread. Having reluctantly eaten a chocolate at her Mum's insistence, Katie gags. The shadow is drawn going down her throat to her stomach, and she leaves the room, looking back at her Mum and sister tucking into the selection box (p. 105). On the following wordless double page spread Katie tries to purge to get rid of the chocolate (pp. 106-7). Above and behind the drawing of Katie's avatar, leant over the toilet, and taking up most of the pages, is the shadow, which contains three naked bodymind avatars. As well as surrounding these avatars, the shadow is trapped within them, extending from the neck down to the navel. The first avatar clutches at her throat, almost strangling herself, gagging; the second claws at her hips, which are flayed and ragged; and the third reaches into her mouth and grabs the shadow from the inside (pp. 106-7). Where the second avatar has torn at her hips, the shadow that was trapped within her, going from throat to stomach, leaks out into the surrounding scribbles. On the third avatar, where Green draws Katie's arm disappearing into her open mouth, she also, disturbingly, draws the wrist and hand grabbing the shadow from inside of her.

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Figure 25: Thoughts of self-mutilation while purging, pp. 106-07

The use of images rather than words to convey Katie's thoughts of self-harm in these two sequences is particularly striking. Rather than describing Katie's mental pain and thoughts of self-injury, Green depicts them on the body by drawing imaginary avatars that represent the bodymind. The lack of text to signal the transitions between representations of Katie's physical, situated avatars, and her emotional, imagined bodymind avatars emphasises the inextricability of, and permeability between, the physical and the mental. The interchanging between these different kinds of avatars visually represents the reciprocity between mind and body that Troscianko argues is so integral to eating disorders. Yet, while the bodymind avatars emphasise permeability, particularly in the purging sequence where the shadow leaks out from within the body and merges with its surroundings, Katie cannot make herself be sick, thinking to herself 'why won't it come out?' (p. 108), and so, in a very real sense, Katie's body is not as permeable as she would like it to be. Furthermore, these two sequences of images emphasise the violence of anorexia. As far as we know, Katie does not cut herself, however, Green uses images of cutting – through the butcher's cleaver in the first triptych, and her flayed hips (which become a recurring image) in the second sequence – to depict Katie's distress. The ubiquity of images of dieting and exercise in contemporary Western culture mean that it is more difficult to convey the bodily and psychological violence of anorexia through such images. Restricting eating and obsessively exercising are slower, more gradual, accumulative methods of self-injury – we would be unlikely to wince at an individual panel of someone refusing food or walking – and while purging is obviously unpleasant, it is a concept with which we are relatively accustomed. As a result, the situated avatar of Katie leaning over the toilet with her fingers in her mouth does not have the same power as the bodymind avatars, upon which violence is registered in starker, more immediate and graphic ways. These images of self-injury performed by the bodymind avatars – strangling, cutting, tearing – and the lack of text to explain these images are destabilizing. They force the reader to confront the violence of Katie's illness and the extent of her distress.

In contrast, Green also depicts the effects of anorexia on Katie's emotions and sense of self through experimenting with fading. In an early scene in the memoir, Katie, around five years old, asks her Mum what happens if you stop eating, to which her Mum replies, 'Well… you'd just fade away…' '…into oblivion' (p. 33). On the next page Green skips forward in time, with avatars of Katie as a teenager walking across the page accompanied by the shadow, with the caption 'Years later, I learned what oblivion meant […] By then I was wishing for it,' (p. 34) and then cuts to an avatar of Green the artist crying over her drawing. Green returns to Katie's innocent question when Katie is taken to hospital and diagnosed with anorexia, repeating the frames of this childhood episode, and layering them on a double page spread with scenes from the diagnostic encounter and Katie as a young adolescent, on the scales, reacting to her diagnosis (p. 149). Recurring intermittently throughout the memoir, fading and oblivion haunt the narrative, and the comics form allows Green to experiment with the concept of fading in ways that are inaccessible to prose.

Green expresses the impact of anorexia on her bodymind by manipulating the tone and definition of Katie's avatars. Splitting a double tuck page horizontally into four equal size panels, Green draws twelve images of Katie's avatar walking in a line across the frames, a cloud scribble above each head, with her body becoming gradually less and less defined and wasting away as the sequence progresses (pp. 124-25).[97] The lines Green uses to depict each avatar become increasingly wobbly and she decreases the level of detail with which each avatar is drawn. While the first avatar in the top left hand corner of the page clearly depicts Katie, hair tied back in a ponytail, tying on a scarf, the last avatar, in the bottom right-hand corner, is drawn using just four lines, and is a shadowy wisp, which is only identifiable as Katie

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[97] I have copied the images from the e-Book of *Lighter than my Shadow* for better picture quality than scanning the memoir by hand, however this means that it is sometimes difficult to see where panels would naturally be divided by the spine of the text. Unlike most comics artists, Green does not use drawn boxes as grids in which to contain her images, but folds the paper after the drawings are complete and then scans them into her computer to add the background colour. This is yet another example of one of the writers in this thesis refusing to contain their experiences within circumscribed boxes.

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Figure 26: Experimentations with fading, pp. 124-25

because of the gradual fading that has taken place across the sequence. Green uses three different shades of grey on these pages: the darkest tone represents the ground, the mid-tone occupies the rest of the background, and Katie's avatars are filled in the lightest shade. The final avatars rely as much on the contrasting shades of grey on the page for their definition as they do any outlines. By reducing the amount of line work for each avatar, and contrasting these three shades of grey, Green literally depicts Katie becoming lighter than her shadow. Fading, like shadows, plays with presence and absence. When Green first starts emphasising the effects of anorexia on Katie's body, she does so, as previously stated, by drawing in more and more detail on her avatars, for example collarbones and vertebrae. In this way, as Katie's body diminishes, it ironically asserts a greater presence on the page. However, in this sequence, we have the opposite. Here the impact of anorexia on Katie's identity is conveyed through her body's gradual fading into nothingness, which is presented as a kind of oblivion.

After her diagnosis, Katie is withdrawn from school and cared for at home by her parents. Following a strict meal plan and attending therapy, Katie gains weight quickly, despite the distress it causes her. Her determination to 'get recovery right' (p. 176) means that she forces herself to eat, resists purging, and gives model answers to questions in therapy. This lulls her practitioners and parents into a false sense of her recovery. Whilst she regains a healthy weight and returns to school, Katie does not feel any different, thinking 'I'm just fatter… Nothing else has changed at all' (p. 209). Her treatment is so focussed on gaining weight and measuring recovery by that metric that it does not deal with any underlying psychological issues. When Katie stops making progress in therapy, she starts seeing an alternative healer, Jake. Katie's sessions with Jake take place in a tepee in the countryside. His therapeutic work is vague: when Katie's mum asks her what he does, exactly, Katie replies that 'It's hard to explain… He gets me to relax, breathe deeply, then he moves my negative energy or something' (p. 234). Despite, or rather, in part because of her mother's misgivings, and because of her desperation to find something to "fix" her, to finally "be recovered," Katie starts having regular sessions with him. Green gives no indication of the abuse that is occurring at this juncture. Instead she draws the sessions as innocent, if slightly mystical – Katie lies on a mattress and Jake holds her hand, or puts his hands on her brow or stomach. He then tells her to relax, that she is safe, and to let herself drift away (pp. 240-41). Multiple images of Katie's body float around them on a lighter wash background with white specks, which look like stars. The only indication that something is wrong is that Katie binges for the first time the night after her first full session with Jake. However, this is drawn as an isolated, random incident at this stage, which is soon glossed over and forgotten in the density of the text.

It is not until Katie goes away to a festival with Jake and his family roughly a year later that Green draws sexual assault. This incident of assault takes up the whole page, most of which is covered in the scribbled shadow. Out of the shadow emerge four circular frames highlighting moments of the assault: a close up of Jake's hand on Katie's breast, with her hand pushing his arm away; another frame takes a different angle and shows his hand unbuttoning her jeans; another shows his hand down her jeans, Katie pushing his arm away, and, disturbingly, the lower half of his face, which is smiling; and another is a close up just of his hand down the front of her unbuttoned jeans. In smaller frames coming out of the shadow are the words 'stop it,' getting progressively bigger, and changing from lower to upper case. The first frame on the next page zooms out to show Jake over Katie, her leaning up and pushing him away, shouting 'STOP IT!' (p. 309). The next three frames show Katie looking upset and confused, pulling away from him, and leaving the tent (p. 310).

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Figure 27: The shadow and sexual assault, pp. 309

In *Graphic Women*, Chute argues that comics about sexual assault write back to the 'dominant tropes of unspeakability, invisibility, and inaudibility' that abound in trauma theory.

> There is the iconic nature of the traumatic image – the fact that the intensity of trauma produces fragmented, imagistic memories. One can argue that trauma itself breaks the boundaries of form, and perhaps can be, at least in part, communicated viscerally and emotionally through the visual. And comics may be particularly situated to express traumatic histories because its basic narrative form works with a counterpoint between presence and absence, from frame to gutter to frame to gutter.[98]

Rather than valorising absence, graphic narrative, Chute argues, emphasises the importance of presence, 'however complex and contingent' and controversial.[99] In her memoir Green chooses to show, rather than suggest, the scene of sexual trauma. However, Green

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[98] Chute & Dekoven, p. 193.

[99] *Graphic Women*, pp. 2-3.

complicates the depiction through her use of the shadow. Comics artists either tend to put assault in the gutter, meaning that the reader knows it has happened because of the process of closure – as is the case with Lynda Barry's *One Hundred Demons* (2002) and Una's *Becoming Unbecoming* (2015) – or they make the abuse violently explicit and grotesque, as for example in Phoebe Gloeckner's *A Child's Life* (1998) and *The Diary of a Teenage Girl* (2002). In contrast, Green's use of the shadow means that the assault is simultaneously highlighted and obscured. Rather than using the blank space of the gutter, Green fills in-between the panels with the scribbled shadow, disrupting the customary rhythm between presence and absence. The way in which the panels depict snapshots of the violation emerging out of the shadow enacts the surfacing of Green's repressed and fragmented memories. The shadow is also key to indicating that the incident is abusive. In a different, consensual context, the images within the panels could be titillating. However, the shadow's associations with pain and distress cement the violence of the frames.

Katie actively represses the incident of assault that takes place at the festival. Running away from the tent into the woods, Katie sits curled up under a tree, distraught. Remembering her Mum's misgivings, she asks herself whether Jake had ever wanted to help her or whether she had just convinced herself that this was the case. Realising that '[her] whole recovery is based on this… on him…', the shadow surrounds her and cracks start to appear in her head (p. 313). Recognising the precariousness of her recovery, and how contingent it is upon Jake is completely overwhelming. On the next page, three images of Katie's head float in the shadow cracking and breaking into fragments. In a panel underneath Katie still sits under the tree clutching her head and decides 'NO', 'This didn't happen', 'This didn't happen' (pp. 314-15). Katie then traps the shadow, now containing drawings of hands reaching for her, in a

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Figure 28: Realising the precarity of recovery, p. 313

box, buries it, and walks away. The narrative then enacts this repression: the shadow temporarily disappears and no mention is made of the assault. Katie returns to university, though her avatars are noticeably thinner and she is shown becoming increasingly obsessive over her work and exercise. Most significantly, Katie starts binging and this fuels her self-disgust and triggers a punishing cycle of restriction, exercise and binging episodes. No matter how hard she tries, Katie is unable to prevent herself from binging and does not understand why she has started compulsively eating. It is only when a flatmate catches her during an episode in which she is eating food from their bin that Katie acknowledges she has a problem and seeks help. When her GP fails to take her problem seriously – 'At least you're eating, eh?' (p. 359) – her flatmate, unaware of the sexual assault that has taken place, suggests that Katie sees Jake.

'Jake?' Katie asks, the shadow appearing next to her avatar and taking the shape of a body. 'I haven't thought of him in a while…' (p. 361). Here, the shadow seeps in from the edges of the panel. The next panel down shows the top half of Katie's face completely surrounded by shadow, with spectral, disembodied hands emerging from the shadow reaching for her. Over the next pages, Green juxtaposes and layers images of Katie running through the woods, as she did after the assault, with her sitting next to her flatmate, who asks her 'what's the matter?'. Green contrasts the spectral hands that reach out from the shadow, with her flatmate reaching out in a gesture of care. Over a series of panels Katie says 'I just remembered…' 'He…Jake…' 'He…t..t..' 'He touched me,' and four disembodied hands reach out for Katie, who is curled up, grimacing. Her flatmate assures her that it wasn't her fault, that 'this never should have happened…' and Katie replies, again over multiple speech bubbles, 'but it did… …and…' '…and…' '…I think…' '…I think… …I think it happened before...' (p. 363). In this hesitant moment of realization, Katie's head cracks open and the shadow bursts out. Like Washuta, who 'forgot so much, but in the years following […] began to remember,'[100] Katie

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[100] Washuta, *My Body is a Book of Rules*, p. 95.

initially represses the multiple incidents of assault. What comics can do, in a way a prose text struggles to achieve, is enact that repression.

Over the next few pages the narrative returns to scenes of Katie's initial "therapeutic" sessions with Jake. The starry wash, which made their sessions feel mystical, is replaced by scribbled shadow, which takes up most of the background and, as with the scene of assault at the festival, panels emerge from it depicting Jake molesting Katie, who is lying down, eyes closed in some kind of meditative trance (pp. 366-67). Here the shadow not only indicates the surfacing of repressed memories, but also Katie's lack of consciousness as the abuse takes place. More avatars of Katie watch the scenes unfolding from the shadow. Framed by the shadow are text boxes asking 'Why can't I open my eyes?' 'Why can't I speak?' 'Why can't I move?' and 'Why can't I tell him to stop?' It is unclear as to whether these thoughts belong to Katie from the time of the abuse, the avatars of Katie retrospectively observing the scene, commentary by Green the artist, or all of these together. By omitting the abuse from the narrative until this juncture, Green mimics Katie's repression: the return to these initial encounters with Jake both reveal and confirm the ongoing molestation to which Katie was being subjected. Until this point the reader, like Katie, has both known and not-known that Jake was assaulting her. As was the case with *Marbles*, *Lighter than my Shadow* establishes a triangulated power dynamic between the subject Katie, the narrator/writer Green, and the reader.

In *Graphic Women*, Chute asks, 'What does it mean for an author to *literally* reappear – in the form of a legible, drawn body on the page – at the site of her inscriptional effacement?'[101] Here Chute reflects on the processes that lead up to an author drawing her scene of assault and her presence on the page through her subjective, bodily, drawn line. The return to these scenes of assault in *Lighter than my Shadow* extends Chute's question. Not only is Green on the page through her lines, but she literally returns to the scene of her

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[101] p. 3.

effacement by drawing older avatars of Katie witnessing her own previous abuse. These avatars, on their hands and knees, peer over the edge of the shadow into the panels in which Jake is molesting her younger self. One avatar, leaning over, tries to pull the shadow back, like material, with one hand and reaches out for her younger self with the other, but cannot reach her. In personal correspondence with Williams, Green wrote that:

> I am more present and aware now than I was when the events were actually happening […] I was completely numbed by anorexia. I didn't know what it was like to be molested – it felt like I was watching it happen to someone else, like I was in a different place, a different time.[102]

The layering of temporality on the page (through older avatars of Katie watching her younger self) depict Green's description that her experiences of assault was like she was watching the abuse happen to someone else. They also, like the opening sequence of Green watching avatars of Katie's ill body, establish the memoir as a process and form of witnessing. In my analysis of *Marbles* I emphasised the importance of mirror scenes because of how they stage a layered encounter with the self: Forney watches and draws Ellen looking at herself and drawing. Here in *Lighter than my Shadow* we have another instance of such duplication: Green works through and witnesses her abuse by drawing avatars of an older Katie watching her younger self being assaulted. The visual nature of comics, the way temporality can be spliced and layered, and the connections and separations between avatars and the artist renders it a particularly powerful medium for narrating and witnessing abuse.

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[102] Williams, 'Autography as Auto-Therapy,' p. 365

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Figure 29: Katie retrospectively witnessing her abuse, p. 367

The trauma of sexual violence and mental illness are particularly entangled in *Lighter than my Shadow* because it is Katie's therapist who assaults her. Katie's realization that Jake had been abusing her throughout their sessions undoes her tentative recovery, which had always been intrinsically linked to Jake and the trust she placed in him. Earlier in the memoir, before either Katie or the reader realize that Jake has been assaulting her, Katie asks herself: 'Could I do it?' 'Leave the old me behind?' 'Just be recovered?' the answer: 'I could if Jake said so' (p. 251). Consequently, acknowledging that he had been abusing her all along prompts a crisis for Katie. Plagued by memories of their sessions and flashbacks of his hands on her body, Katie's only source of comfort is binging and she subsequently relapses into disordered eating; this in turn deepens her sense of self-disgust and compounds her distress. As Katie experiences flashbacks of Jake's words and the feeling of his touch, she repeatedly tells herself that her ‘whole recovery was a lie’ (p. 377). The skin on her bodymind avatars peels away, revealing skeleton and organs, and cracks appear, filled with shadow, until these avatars are torn into fragments (pp. 376-78). Underneath these fragmented bodyminds, Katie lies naked in the foetal position thinking ‘I’ll never recover from this’ and ‘I wish I was dead’ (p. 379), and this is followed by a suicide attempt.

In a wordless sequence over 12 panels, Katie goes to the medicine cabinet and empties a handful of pills (p. 380). On a full page spread, Katie holds the pills in one hand and a glass in the other, the shadow expanding in a column behind her (p. 381). There are two tears in the page in which white breaks through the grey wash background. On the double page spread that follows, Green uses the same image, but has torn it up, scanned it into her computer, and scattered the fragments across a white background (pp. 382-23). The fragmentation of Katie’s distressed bodymind avatars has been replicated here on the drawn page. This, coupled with the abrupt switch to white pages, rather than the tones of grey that dominate the rest of the memoir, provide Green with yet more ways of signalling oblivion. As well as indicating loss of consciousness, the white pages signal a break in the narrative and introduce a kind of dream sequence in which, over seven pages, Katie gets up from the floor, picks up a pencil and starts drawing. Facing away from the reader, Katie has drawn, and is still drawing, a montage of the memoir so far; including scenes rollerblading with her best friend, walking to school, being bullied, sitting at the dinner table, the shadow, and running from Jake’s tent (pp. 394-95). The spread acts as a condensed recap of the narrative, and is unfinished, signalling that the suicide attempt is not an ending, but an intermission. Yet another example of Diedrich’s drawing en abyme, this spread further establishes drawing as a method of processing.

This is extended even further when, after another blank white page, Green draws another image of Katie, faced away from the reader, pen in hand. Opposite Katie is a faint reflection of her avatar, the lines of which Katie is going over in pen and solidifying (p. 397). This image encapsulates Forney's remark in *Marbles* about the soothing effect of drawing her own reflection: 'in my sketchbook, I'd trace the familiar lines of my face, & I'd calm down & come back into myself'.[103] Here Katie is literally tracing the lines of her body. Notably, unlike the distorted and partial reflections of Katie's avatars in mirrors, which dominate the memoir, in this moment Katie sees her reflection accurately. The lines of her body are, for the first time, familiar, rather than alien. Tracing and emboldening the faint lines of her reflection is an act of agency. Katie (and by proxy Green) gains control over her body, not by restricting, or purging, or exercising, but by drawing it. Whereas previously in the memoir Green draws Katie's avatars fading into shadowy wisps, here the faint lines are being made solid, dark, and definite. Rather than fading into oblivion, this is an assertion of embodied presence. Notably, as with the spread described above, Katie's drawing is unfinished, which nods towards the work that is left to be done and, as depicted in the remainder of the narrative, Green's commitment to recovery as ongoing, rather than an achieved state.

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Figure 30: Drawing as an assertion of presence, p. 397

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[103] Forney, *Marbles*, p. 98.

In the aftermath of the suicide attempt Green interjects a page of prose that contextualises the dream sequence. This is the first, and one of the only times that Green chooses writing over drawing to communicate with the reader. In this narrative interruption Green writes that her memory of that time is ‘muddle[d]’ and that ‘looking back, it’s easy to think that things change in that single moment.’ ‘Certainly,’ Green continues ‘it’s more dramatic to tell it that way’ (p. 403). Green admits that she had many suicidal moments in which she repeatedly decided to stay alive, and we know from the recording of Green talking about her work with which I opened the thesis, that she only included one of these for the sake of narrative flow. During this time, Green continues, her mantra became:

> ‘I want to live.
> I want to draw.’ (p. 403).

It is fitting, then, that the dream sequence that follows Katie’s overdose is dominated by images of Katie drawing her life and her body.

The rest of the memoir is dedicated to Katie’s recovery from disordered eating and symptoms of post-traumatic stress disorder. Katie sees a psychotherapist regularly and together they unpack the continuing repercussions of her sexual abuse and her complex relationships with food and her body. Katie also finishes her degree in biology and decides to attend art school, where she gains confidence. Though she continues to experience flashbacks and have episodes of binging, these become less frequent, and Katie slowly learns how to look after herself when distressed. Recovery, this time, is drawn as a gradual, unsteady, ongoing process, with many setbacks, rather than a linear trajectory to a conclusive, medically-recognised state. Instead of being focused on merely the physical symptoms of her disordered eating, Katie’s recovery is drawn as a reciprocal process between mind and body, one that respects and foregrounds their interconnections. Consequently, recognising and working through her history of sexual abuse is integral to this process.

Lighter than my Shadow ends on a sequence of three images that emphasise the memoir as a form of witnessing. On the first, an avatar of Green stands in the foreground on a road that winds behind her off the top of the page. Looking back down the road, where she has come from, is a condensed ball of shadow (p. 504). On the second image, the setup is repeated, but the shadow has been replaced by an avatar of Katie as a young girl, clutching her teddy bear, crying (p. 505). On the final page of the memoir, Green, smiling, crouches down next to the young Katie, and reaches out to comfort her (p. 507). Like the end of *Marbles*, *Lighter than my Shadow* closes with a layered encounter between an older and younger self. In both instances avatars of the artist are able to provide reassurance to images of their younger selves. Green and Katie do not merge in the way Ellen and Forney do, but this would be

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Figure 31: Green comforts Katie, p. 505

inappropriate at the end of a coming-of-age narrative. Green is no longer the sobbing child, but the adult artist who has lived through anorexia and abuse, and found a means or processing them, through drawing. The winding road of the penultimate images frames the narrative as a journey, but rather than having arrived at a final destination, Green's position on the road, which also stretches in front of her off the page, indicates that this journey is ongoing. Like the end of *Marbles*, *Lighter than my Shadow* resists a neat, triumphant conclusion. Instead, both Forney and Green emphasise that the end of their memoirs are simply the end of that part of the story, and their lives, and relationships to their illnesses, will, of course, continue after the final pages.

The respective endings of *Marbles* and *Lighter than my Shadow* contrast with that of *On Sanity*, with which I opened this chapter. *On Sanity* ends abruptly with a fight between Una's mother and another patient over what to watch on television during her institutionalisation. Unlike Forney and Green, Una does not narrate the process of her mother's recovery and return to life outside of the unit. Throughout this thesis I have analysed memoirs that problematise the simplified trajectory of the overcoming, or Recovery Narrative, as discussed in my introduction.[104] However, in *On Sanity* the recovery narrative is completely absent. Instead the text ends with some 'afterwords' by Una and 'afterthoughts' by her mother. In Una's afterword, she writes that her mother 'has something of importance to say, because her recovery was slow and not easy, with many setbacks'. She emphasises that her mother's narrative is important, precisely because her recovery was gradual and non-linear, but omits this part of the story from the memoir in order to provide a cross-section of a single day in a life experiencing mental illness. In her 'afterthoughts' Una's mother shares details about her multiple hobbies, volunteering, family activities, and holidays. She is, she emphasises, 'happy and positive' and 'no longer angry and paranoid, or in despair'. She writes that she has accepted that she must take her medication for life because without it she

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[104] Angela Woods, Akiko Hart, and Helen Spandler, 'The Recovery Narrative: Politics and Possibilities of a Genre', *Culture, Medicine, and Psychiatry*, (2019), 1-27 <https://doi.org/10.1007/s1101>.

relapses. She celebrates that she 'now feel[s] normal' because 'it was a hard journey from having no hope during my illness'. Again, it is particularly striking that this journey is omitted. Describing her mother's mental illness as 'labyrinthine in complexity', Una laments that the book cannot do it justice, and instead chooses to take 'only a single slice of time from the whole story'.

Una's 'single slice' and Green's 508 page long graphic memoir are narratives of mental illness drawn on oppositional scales (with *Marbles* in the middle at 237 pages). Yet, despite their different sizes and scopes, central to all of these graphic memoirs is the use of the visual, as well as the verbal, to narrate the complexities of living with mental illness. In this chapter I have shown what comics bring to critical discussions of illness narratives. I established from the outset that comics is an inherently relational form and subsequently examined the ways that words and images interact to amplify and/or destabilise each other. The layering of elements on the page, and the ambiguities, contradictions, tensions, and disruptions that arise from their interplay, are especially suited to narrating messy stories of mental illness and distress. Moments of textual silence, where images are allowed to speak on their own, also maintain the complexities and nuance of experiences of illness and abuse in a way that prose sometimes struggles to achieve. An embodied form, comics' manipulation of avatars highlights the bodily experiences of illness and distress in a way that is often obscured in prose. Graphic narratives' capacity for multiplicity, layering, and assemblages, as well as emptiness and silence renders it a particularly generous form in which to construct illness narratives.

Each of the artist-writers in this chapter use comics to (literally) reframe and work through experiences of mental illness. Una's relational graphic memoir reframes her mother's mental illness by prioritising the domestic and the ordinary over the biomedical and clinical. Forney takes her diagnosis of bipolar disorder out of the 'inanimate stack of paper' that is the *DSM* and re-contextualises it as part of a wider, richer life narrative. *Marbles* is celebratory in its excessiveness and the way it overspills diagnostic criteria, narrative typologies, and, frequently, its own comics grids. Green mobilises comics as a means of textually recuperating her enmeshed histories of disordered eating and sexual abuse. My reading of *Lighter than my Shadow* has analysed how mental illness, distress, and sexual violence are entwined experiences, as was also the case in *Lying, My Body is a Book of Rules, Welcome to my Country*, and *Stuart*. Green’s knotted drawings of shadows visually depict her experiences as entanglements, which, as I emphasised in the introduction to the thesis, are at the heart of the critical medical humanities.

Conclusion: Reflections on mental illness as ongoing

In February 2019, Elissa Washuta published an essay in the magazine *Guernica* entitled 'White Witchery'.[1] In the essay she returns to the entangled issues of mental illness, sexual violence, and colonialism that interwove throughout her memoir, *My Body is a Book of Rules*, discussed in Chapter One. The publication of this essay confirmed my conclusion that these were experiences that Washuta would repeatedly have to come back to, keep coming to terms with, and keep working through. *My Body is a Book of Rules*, I argued in Chapter One, was not a memoir about recovery or resolution, but about the labour Washuta undertook (and continues to undertake) to contextualise and try to make some kind of sense of the intersections of her bipolar disorder, disordered eating, history of sexual violence, and Native American ancestry.

The essay in *Guernica* is about Washuta's turn towards witchery and spiritualism as means of accessing power to cope and heal, and about how traditional Native American and occult practices have been perverted by their white appropriation and commercialisation. Having spent months on various waiting lists trying to access therapy then undergone an appointment with a therapist who referred her onward because Washuta had experienced too much trauma to take her on as a client, and at the time of writing still awaiting the appointment from that referral, Washuta writes about how she chooses witchcraft to help assert her agency while struggling with the 'tyrannical rule of [her] PTSD triggers' and unable to access adequate mental health care.[2] As we know from *My Body is a Book of Rules*, witchcraft and spiritual remedies are neither the first nor only methods that Washuta has used to try to manage her mental health. For her moods, Washuta writes, she has

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[1] Elissa Washuta, 'White Witchery', *Guernica*, 14 February 2019 <https://www.guernicamag.com/white-witchery/ > [accessed 2 September 2019].

[2] Washuta, 'White Witchery', para. 17.

> tried Lexapro, Seroquel, Lithium, Lamictal, Wellbutrin, Zoloft, Celexa, Ativan, Klonopin, and Abilify. For [her] night fear, [she has] tried L-theanine, melatonin, tryptophan, magnesium, Benadryl, and dropperfuls of herbal tinctures. Ten years of antipsychotics, prescribed by a psychiatrist who diagnosed [her] with bipolar disorder, didn't work.[3]

In 2015, Washuta continues, having been sober for a few months, a psychiatrist specialised in addiction changed her diagnosis to alcohol-use disorder in full sustained remission and post-traumatic stress disorder. This psychiatrist told her that 'it was unlikely that [she] had ever been bipolar' and, given that her medications were unsuitable for her new diagnosis, helped her taper off them.[4]

Consequently 'White Witchery' revises and destabilises much of the content of *My Body is a Book of Rules*. In her memoir, Washuta strongly identified with her diagnosis of bipolar disorder and framed it as an integral part of her selfhood; she wrote that 'when [her] doctor finally put his finger on the bipolar diagnosis, pulled there like a knowing planchette skidding across an Ouija board to a spectral message, [she] felt relieved to have finally arrived at an answer'.[5] Yet, a year after the memoir's publication, she learnt that bipolar was not the final answer, that it had most likely been an incorrect diagnosis, and consequently the drugs she had been prescribed, many of which she had had adverse reactions to, had been inappropriate. Unlike the relief of receiving her diagnosis of bipolar, receiving the determination of PTSD 'frightened' Washuta because her 'triggers and trauma had been allowed to multiply unchecked'.[6] Like Kaysen's *Girl, Interrupted* and Slater's *Lying*, Washuta's article demonstrates the uncertainty of diagnostic practices and reminds us of both the material and existential implications of misdiagnoses. Notably, Washuta's new diagnosis of PTSD reframes the interactions, or better, intra-actions, between her mental states and history

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[3] Washuta, 'White Witchery', para. 23.

[4] Ibid., para. 24.

[5] Washuta, *My Body is a Book of Rules*, p. 155.

[6] Washuta, 'White Witchery', para. 25.

of sexual violence.[7] Rather than being separate entities that interweave, occasionally intersecting, Washuta's struggles with her mental health are now contextualised as a direct result of her numerous experiences of rape and assault. Her diagnosis of PTSD recognises the lasting impact of sexual trauma in a way that her misdiagnosis of bipolar failed to do. As I have argued in my readings, not only of Washuta's life writing, but also Slater's *Lying* and *Welcome to my Country*, Masters' *Stuart*, and Green's *Lighter than my Shadow*, experiences of sexual violence and psychological distress, often interpreted within the framework of mental illness, are enmeshed.

Diagnoses are, as I have repeatedly demonstrated in this thesis, contingent endeavours. But so too are modes of reading. In her advocacy of the ways in which literary perspectives can shed new critical light on the medical humanities, Anne Whitehead cautioned against 'the impulse towards mastery across illness narratives', which is particularly exemplified by the approaches of reading adopted within narrative medicine outlined in the introduction to the thesis.[8] 'Rather than subscribing to a dominant impulse towards meaning and control', Whitehead continues, we would benefit from being receptive to 'what the literary can reveal to us about what it means to live in a condition of uncertainty'.[9] In so doing, she suggests, 'we might […] productively connect clinical diagnosis and literary reading as necessarily uncertain, yet essential, modes of interpretative practice'.[10] Many of the texts in this thesis explore states of uncertainty that arise from living with mental illness and distress.

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[7] In their theorisation of entanglement in the medical humanities, Des Fitzgerald and Felicity Callard draw on the work of feminist science and technology studies scholar Karen Barad. Barad's work, they argue, marks a shift from thinking about relationality 'as process of interaction (in which more or less bounded things engage with one another) to one of 'intra-action' – a neologism that refuses *prior* wholeness as the condition of intersection'. Des Fitzgerald and Felicity Callard, 'Entangling the Medical Humanities', in *The Edinburgh Companion to the Critical Medical Humanities*, ed. by Anne Whitehead and Angela Woods (Edinburgh: Edinburgh University Press, 2016), pp. 35-49 (p. 39).

[8] Anne Whitehead, 'The Medical Humanities: A Literary Perspective', in *Medicine, Health, and the Arts: Approaches to the Medical Humanities*, ed. by Victoria Bates, Alan Bleakley, and Sam Goodman (London: Routledge, 2014), pp. 107-27 (p. 115).

[9] Ibid.

[10] Ibid., p. 116.

They have illustrated complex, and sometimes contradictory, relationships to diagnostic labels; the difficulty of remaining drug compliant despite not knowing whether a particular medication would alleviate distress; authors' doubts about their own authority, frequently undermined because of their status as patients; and concerns about being able to adequately witness their own experiences. Furthermore, one of the defining features of these examples of life writing has been the mobilisation of such uncertainty in their formal experimentation. Actively manipulating ambiguity and contradiction as narrative strategies, these writers repeatedly frustrated the reader's diagnostic urge for neatness, clarification, and explanation.

The publication of 'White Witchery' not only illustrates the impact of changes of diagnosis in a life narrative, but also highlights dilemmas that arise from working on contemporary life writing about mental illness. I confess I was daunted when I first read Washuta's recent essay. I was selfishly concerned that the announcement of her new diagnosis invalidated my reading of *My Body is a Book of Rules* and I baulked at the prospect of a substantial rewrite in the final stages of my PhD. I was, I admit, temporarily frustrated that, just as I thought I was tying together the loose ends of the thesis, a new instalment of life writing could be published and disrupt my carefully tailored arguments. But then I realised that this frustration stemmed from the same desire to neatly contain narratives of mental illness and distress within a circumscribed container, which I had critiqued throughout this thesis, and which these writers continually resisted.

If the publication of 'White Witchery' caused me disruption, it also crucially reminded me that disruption has been at the heart of this research. I have, after all, foregrounded interruptions, contradictions, ambiguity, tangles, and messiness throughout my readings of texts. Such aesthetics were present in Kaysen's challenge to authority posed by the inclusion of her photocopied medical records; Slater's controversial appropriations of metaphor and other people's stories as methods of indirectly telling her own illness narratives; Washuta's experimental hermit crab essays; the misunderstandings and arguments between Stuart and

Alexander in Masters' auto/biography; the unresolved disagreements between Patrick and Henry Cockburn as to how to interpret Henry's voice hearing; the twins' interdependent animosity in *Divided Minds*; and the different ways Una, Forney, and Green capitalised upon the capaciousness of the comics form to expand the boundaries of illness narratives. Whether through my attentiveness to multimodality, polyvocality, or hybridity, I have argued that these writers' formal experimentation overspills and bursts conventional narrative typologies of illness. Throughout my analyses, I have consistently asserted the need to engage with transgressive illness narratives and recognise the productivity of their difficulty, as well as interrogating their modes of reading.

It would have been hypocritical of me, then, to celebrate the eruptive capacities of formal innovation within these memoirs but turn away from the disruptions that continue to happen after their publication. These texts are not Recovery Narratives. They are not static, resolved, contained entities, but examples of life writing that narrate mental illness and distress as states of flux. The publication of Washuta's 'White Witchery' essay emphasises the fact that mental illness and distress are *ongoing* states, and it is important to remember that this is not an exception to the rule, but the norm. Consequently we need critical methodologies that recognise the messiness, shifts, and uncertainties that surround experiences of mental illness, not just within narratives, but also after they have apparently finished. As I have shown, literary studies readings that are guided by the terms set out in their primary texts and embrace flux can resist the temptation to impose neatness on disruptive articulations of complex experiences.

Developing methodologies that negotiate issues of uncertainty, entanglement, and risk is, I have demonstrated, a fundamental part of the work of the critical medical humanities. My readings of life writing within this thesis would have been extraordinarily limited had it not been for my engagement with the ongoing scholarship on illness narratives being undertaken within this emerging field. Establishing this project as one that builds on work by Stella Bolaki, Brendan Stone, Sara Wasson, Whitehead, and Angela Woods equipped me with the tools to attend to the shifts and disruptions outlined above. My analyses of the memoirs in this thesis have responded to calls made by these scholars to engage with complex narrative articulations of illness; reconfigure narrative identity in relation to the fragmentary, momentary, and episodic; recognise and celebrate the multiplicity of illness narratives; and read with an expanded notion of literary genre. Furthermore, I have extended their interventions by drawing on concepts and frameworks from different disciplines – including critical disability studies, critical trauma studies, autobiography studies, and comics studies – to analyse the strategies with which writers construct narratives about mental illness in contemporary life writing.

My focus on form has allowed me to be led by these writers' own theorisations of how to tell narratives of mental illness and distress. Given my emphasis on the permeability and contingency of diagnostic categories, it would have been inappropriate for the thesis to trace the representation of a specific diagnosis of mental illness in contemporary texts. It was through establishing a methodology that prioritised critical modes of articulating mental illness that enabled me to recognise and adapt to these writers' disruptions and entanglements without, I hope, appropriating them. Given the continuing nature of mental illness and distress, and the way those states exceed not only narrative typologies, but the narratives themselves, it needs to be stressed that this conclusion can only present the summary of its work as ongoing. Living in states of mental illness is a shifting, precarious, and unsettled position and there is a continuing need to fashion methods of reading that are receptive to the complexities that arise from such disruption and instability. As conditions come and go from the *DSM*, symptoms change, medications are switched, and triggers return, the need to write and draw life writing about mental illness persists. Trying to be precise about the moving object is always a critical challenge, but it is one, I would argue, that literary and cultural criticism, working with interdisciplinary methodologies, can and does achieve.

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